

Final Summary/Report: Addressing Unmet Need for Family Planning in Rural Areas: Introducing Community-Based Distribution of Injectable Contraception

Delphine Liston, FHI

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Leadership, Management and Sustainability Program
Management Sciences for Health
784 Memorial Drive
Cambridge, MA 02139
Telephone: (617) 250-9500
www.msh.org/lms

FINAL SUMMARY/REPORT

“Addressing Unmet Need for Family Planning in Rural Areas: Introducing Community-Based Distribution of Injectable Contraception”

A Virtual Forum on the Global Exchange Network (GEN) for Reproductive Health

A Partnership Between:

Management Sciences for Health
Leadership, Management and Sustainability Program (LMS)
784 Memorial Drive
Cambridge, MA 02139
Telephone: (617) 250 9500
www.msh.org/lms

AND

Family Health International
Contraceptive and Reproductive Health Technologies Research and Utilization Program (CRTU)
2224 E NC Hwy 54
Durham, NC 27713
Telephone: (919) 544-7040
www.fhi.org

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I. EXECUTIVE SUMMARY

Injectable contraception is an extremely popular contraceptive option due to its safety, effectiveness, ease of use, privacy, and convenience. However, it is often difficult for women in rural areas to access clinics where injectables are provided. In order to address this need, several countries have added injectable contraception to existing community-based distribution (CBD) programs. However, this is a relatively new technique, and many health professionals throughout the developing world have little information on how to actually start up such programs in their own countries. Thus, FHI identified a strong interest and need for discussion around CBD of injectables.

Via Management Sciences for Health (MSH)'s Global Exchange Network (GEN) for Reproductive Health, Family Health International and MSH hosted a week-long virtual forum on the topic of community-based distribution (CBD) of injectable contraception during the week of May 21-25, 2007. The GEN website discussion proved to be an ideal opportunity to engage program managers, policy makers, providers and other health professionals from around the world to share experiences and receive guidance on incorporating injectables into existing CBD programs.

The forum had a total of 331 registered participants from 19 countries (including 10 African countries, 2 Latin American countries, 3 Central Asian countries, 1 Southeast Asian country, 2 European countries and the United States). Out of the 188 people who logged in, 51 actively participated in the discussion. The primary themes that emerged during the forum discussion were: general support for CBD of injectables; the need to dispel myths and provide correct misinformation surrounding CBD of injectables; support for new technology; the importance for adequate training; and the importance of creating strong linkages between CBDs and existing clinical services. Both the discussion themes and the large numbers of active participants from diverse regions reinforce the idea that community-based distribution of injectable contraception is an exciting advancement in the field of reproductive health and is of particular interest to many individuals and organizations throughout the world.

II. BACKGROUND

The Contraceptive and Reproductive Health Technologies Research and Utilization Program (CRTU) program is a USAID-sponsored assistance agreement (2005-2010) with Family Health International. Through the CRTU program, Family Health International (FHI) works with USAID, its missions, and other partners to expand the range and support the use and availability of safe, effective, acceptable and affordable technologies for the prevention of unplanned pregnancy and sexually transmitted infections, including HIV.

The Global Exchange Network for Reproductive Health (GEN) is a virtual network of the USAID-funded Leadership, Management and Sustainability (LMS) Program, implemented by Management Sciences for Health (MSH). GEN is a virtual network that allows for exchange and learning among health professionals about leadership and management issues that affect reproductive health programs and organizations in countries that no longer receive United States Agency for International Development (USAID) Population and Reproductive Health (Pop/RH)-funding, are soon-to no longer receive this funding, or currently receive this funding. The Network promotes the exchange of information and best practices on priority management and leadership issues and USAID Global Leadership Priorities (GLPs) such as repositioning

family planning, contraceptive commodity security, HIV and Family Planning services integration, and financial sustainability, among others.

FHI has established a Memorandum of Understanding (MOU) with the Leadership, Management, and Sustainability (LMS) Program of Management Sciences for Health (MSH). One of the major goals of the CRTU is to increase the uptake, implementation, and scale-up of evidence-based best practices in reproductive health. As this is often recognized as a management and leadership challenge, this piece of the CRTU is consistent with the overall goals of MSH and led to a logical collaboration between the two groups.

Within the CRTU program, FHI has identified CBD of injectables as one of its key strategy areas. In 2004, FHI staff conducted a study in the Nakasongola district of Uganda, which demonstrated the safety, quality and feasibility distribution of the injectable contraceptive DMPA by community reproductive health workers. In this study, CBD of DMPA was shown to be as safe as clinic-based distribution; furthermore, women were satisfied overall with community-based distribution of DMPA. Through the CRTU, FHI has sought to promote the translation of evidence-based research into practice through the promotion and dissemination of information about the success of studies (including the Nakasongola project) which demonstrate the feasibility of incorporating injectables into CBD programs. This collaboration with MSH proved an ideal opportunity to promote evidence the use of evidence-based research in reproductive health programs throughout the world.

II. INTRODUCTION

A virtual forum in English on “Addressing Unmet Need for Family Planning in Rural Areas: Introducing Community-Based Distribution of Injectable Contraception” took place over one week from May 21st-25th, 2007.

The facilitators of the forum were: John Stanback, Senior Associate with FHI’s Health Services Research division; and Kirsten Krueger, Senior Program Officer in FHI’s Field Programs division. Both facilitators have extensive backgrounds in the field of community-based distribution (CBD) of injectable contraception.

The goal of this virtual forum was to promote the exchange of information and practices among policy makers, program managers, researchers, and other health professionals. Each day, the facilitators began the discussion by posing a relevant question to which participants responded. At the end of each day, facilitators shared a summary of the day’s discussion, which was posted on the forum and sent out via email. Participants had the opportunity to interact directly with the forum facilitators and participants to share experiences, questions, and answers.

Registered participants were provided access to informative and useful tools, including case studies, to encourage discussion about a variety of issues related to CBD provision of injectable contraception. Three case studies were provided on the GEN site, to aid in discussion: “Feasibility of Community-based Distribution of DMPA by Volunteer Agents in Madagascar” (produced by FHI); “Community-based Distribution of DMPA: The Nakasongola Project, Uganda” (produced by FHI); and “Innovations in Family Planning: The Accelerating Contraceptive Use Project in Afghanistan” (produced by MSH). In addition, FHI staff compiled a variety of additional tools, resources, job aids, training guides and other materials (produced by FHI, the INFO project, Population Council, Pathfinder, MSH and WHO, among others), which were posted to the GEN online library.

IV. FORUM PARTICIPATION

Approximately 2,500 health professionals were invited to participate in the forum, including staff from NGOs, Ministries of Health, Universities, the United Nations and local USAID missions.

There were 331 individuals who registered for the forum, 188 people logged in (100 women). Fifty-one members from 19 countries participated in the discussion, contributing a total of 95 postings in the forum discussion section.

The registered participants were from the following countries:

Country	No. of participants	Country	No. of participants
United States	76	Ghana	8
Nigeria	35	Indonesia	7
Kenya	33	Afghanistan	7
Uganda	20	Switzerland	6
Ethiopia	20	Egypt	6
Tanzania	13	Zambia	5
Pakistan	12	Nepal	5
Rwanda	9	Others	69

V. FORUM CONTENT AND DISCUSSION THEMES

Each day of the forum introduced new guiding questions. The following is a brief summary of each day's questions, and examples of postings participants made in response to the questions. (See the appendix for a complete set of postings and daily summaries.)

Day 1: Do women in rural areas have adequate access to family planning? If not, do you think that provision of injectable contraception by community-based paramedicals is an effective and safe way to improve access?

"Practically speaking injectables are not available in the communities (rural areas), this is due to so many reasons such as poor access, neglect, and the fact that attention of health professionals, policy makers, among others are not properly addressed towards them. Moreso, using community-based-distribution of injectables can be an effective and safe way to improving FP access if the community health workers are properly trained and monitored based on the cultural factors involved in the rural areas concerned."

– Olukunle Omotoso, Nigeria

Day 2: Based on the case studies from Uganda, Madagascar, and Afghanistan, how well did these innovative projects work? How were challenges such as uptake, training, injection safety, supervision, etc. addressed? How can you relate these examples to your own experience?

"Culture and religion play an important part in any intervention. I like the way the Afghanistan Project dealt with the cultural and religious issues which helped the health workers' and clients' acceptance of the different family planning methods. For instance the project related family planning to Islamic teachings and was able to get the Mullahs to talk about FP in the mosques and other religious gatherings."

Using dialogue with the communities is important as this builds the communities' capacity to handle their problems [...] [Community dialogue] can be used to deal with misconceptions that many people have about Depo and thus scale up CBD of DPMA in the rural areas.” – Hilda Sekbira, Uganda

Day 3: In your country, what steps can be taken to overcome medical and political obstacles to introducing CBD of injectables? Which stakeholders need to be sensitized and supportive to ensure successful uptake of the intervention?

“In many cases the medically trained fraternity are a huge obstacle - we generally tend to feel that community based distribution of injectables is taking work from us. One way of handling this is to involve other community resources e.g. private midwives, drug shops where they exist in the community. Otherwise, we need to help medically trained people to realise that rather than taking our work from us, community based distribution is making loads at the health centers lighter and is meeting a need (even a human right) of underserved women.” – Angela Akol, Uganda

“Having participated in a study tour of the Uganda CBD DMPA project, the political and legal concerns were addressed by adopting a “research” approach for the pilot, which took care of ethical and legal concerns therefore giving little room for political “disruptions”. A similar approach could be used in Kenya [...] In Kenya, the community [...] is recognized, in the RH policy documents as the focus for health interventions; therefore the sensitization process should start at this level.” – Njeri Mukoma, Kenya

Day 4: In your country, are autodisable (AD) syringes used? Will new technologies such as autodisable syringes and Depo subQ help overcome objections to CBD of injectables, or do such objections have more to do with clinicians' status than paramedics abilities? Will future CBD workers merely furnish women with their Depo subQ, which women will inject themselves?

“AD syringes are not widely used in Kenya. [...] Therefore to address the issue, proper mechanism should be put in place to ensure regular supply of ADs should CBD of DMPA be introduced.” – Fredrick Ochieno, Kenya

Day 5: In your country, could CBDs link with public sector facilities for supplies and referrals? How would clinic-based providers react to such an arrangement? How can CBDs help women access long term and permanent methods that are unavailable locally?

“For sustainability of the programme and better management of problems and situations that may arise from the application of the contraceptives as well as provision of longer term contraceptives, the CBD's should be actively linked to a health facility.” – Olusesan Makinde, Nigeria

Some of the broader themes that arose throughout the week were:

- **General support for CBD of injectables:** Overall, more people favored CBD of injectables, or thought it had promise, than were against it. Of the 24 participants who said they supported it outright, most did so only if certain conditions were met. However, most participants seemed to agree, overall, that CBD of injectables is generally a positive innovation, as long as proper training, safety, community participation and cultural awareness factors were considered. Quite a few participants mentioned the potential benefit

to clinic-based providers whose workloads would be reduced when CBDs provide routine family planning.

“Community based distribution of injectables would go a long way to increase access due to the fact that these CBDS are found where the services are needed, the CBDs know their communities better [...] all these people would need is intensive training and close supervision. Medical personnel were not such until after training.” – Jully Chgilambwe, Zambia

- **The need to dispel myths and correct misinformation surrounding CBD of injectables:** Sensitization and education were mentioned by many participants as critical activities for overcoming resistance, myths, and misconceptions surrounding CBD of injectables.

“Using dialogue with the communities is important as this builds the communities' capacity to handle their problems [...] [Community dialogue] can be used to deal with misconceptions that many people have about Depo and thus scale up CBD of DPMA in the rural areas.” – Hilda Sekbira, Uganda

- **Support for new technology:** There was general agreement among contributors that both AD syringes and the new subcutaneous formulation of Depo Provera (“Depo Sub-Q”) would be very welcome and would certainly help the uptake of CBD of injectables.

“Auto disposable are not common in Nigeria but available for nationwide immunization. [...] This would go a long way at overcoming some of the anticipated problems expressed by some commentators on this forum. I am fully in support of auto disposable syringes.” - Baba Issa , Nigeria

- **The need for adequate training:** Many participants commented that even if new technologies, like self-injection became available, that proper sensitization, training, a secure commodity chain, and client follow-up are still needed.

“Community based distribution of injectables would go a long way to increase access due to the fact that these CBDS are found where the services are needed, the CBDs know their communities better [...] all these people would need is intensive training and close supervision. Medical personnel were not such until after training.” – Jully Chgilambwe, Zambia

- **The importance of creating strong linkages between CBDs and existing clinical services:** Nearly all participants believed that CBD of injectables programs should be linked to public sector health facilities (and already are in several countries) as a key to the sustainability and quality of the program. Linkages between CBDs and clinic staff should be started early and can include joint training, joint monthly meetings and reports, supervision, resupply, and even assistance from CBDs with other health initiatives such as immunizations or food distribution.

“Re-orienting health systems so that [clinic-based providers] concentrate on providing only the services that no one else can do and putting anything that can be delegated into a community program or the private sector, would go a long way towards improving coverages and stretching scarce resources, especially trained medical human resources.” – Jason Smith, United States of America

VI. FACTORS OF SUCCESS

Elements of success of the forum were:

- The teamwork, collaboration and support from and to both organizations
- Focus on a topic that is innovative (readings and postings helped to raise awareness and generate discussion)
- Inclusion of health professionals with a variety of experience levels (this provided a wonderful opportunity for those with more experience to share information with those newer to the topic)
- Having technical leads available to assist with logistical questions (e.g., Douglas Huber at MSH, Angela Akol at FHI Uganda)
- Not limiting the geographical focus of the forum (this allowed for maximum diversity of participants)
- Including a comprehensive library of materials to which the participants could refer during the forum (this library will remain on the GEN website for future reference)

VII. EVALUATION COMMENTS

Selected comments from the Virtual Forum Evaluation Forms:

Please give some examples of how you applied or plan to apply what you learned in this forum to your work.

“We are yet to commence CBD Injectable programs in Nigeria but I have learnt a lot from the case studies and I have no doubt that the lessons will be come in handy when we begin our programmes.” – Adeyemi Adekunle, Nigeria

“I will use the knowledge to strengthen what is being done in Uganda regarding the revitalization of DPMA when the Revitalization Committee meets again, to advocate at MoH Senior Management and get more financial backing for CBDs for DPMA.” – Hilda Sekabira, Uganda

“I plan to do a sensitization for women groups in my community to let them know the advantages of injectables as a good method of birth control.” – Folayinka Akinpelu, Nigeria

What suggestions do you have for future forums?

“I think we should do this more frequently. It has been very stimulating. Thanks to the organizers.” – Adeyemi Adekunle, Nigeria

“Do it regularly. I have learned a lot with different people without traveling or disrupting my work. Establish these forums even in other fields eg: AIDS, UNSAFE ABORTION etc.” – Oscar Nkatilo, Tanzania

“Keep bringing issues that could be “owned” by the communities.” – J. Rolando Figueroa, El Salvador

VIII. RECOMMENDATIONS

Some recommendations for future forums are:

- Provide better instruction on how to post comments (i.e., on the GEN website, not in email form)
- Try new ways of providing assistance to participants with slow internet connections or limited technological skills
- Reconsider the assignment of case studies as “required reading”
- Find new ways of supporting and engaging technical leads
- Provide more explicit information to participants about the use of their contact information on the GEN website
- Encourage those who have logged in but not posted comments to participate in the discussion

IX. WEBSITE INFO: GLOBAL EXCHANGE NETWORK (GEN)

The content of the GEN forum on CBD of injectables is still available on the GEN website as of July 30: <http://globalexchange.msh.org/>. If you are not registered for the GEN website, you can do that on the GEN website as well. If you have questions, please send them to globalexchange@msh.org.

APPENDIX 1:

CBD of Injectables Forum (May 21-25, 2007)

Note: The daily summaries are listed below followed by all postings associated with the discussion thread for that day.

Day 1 - Discussion Thread

Poor women who live in rural areas may have particular difficulty accessing family planning services. Where women prefer injectable contraception but clinics are few, one option is provision of injectables by community-based health workers. In rural areas where you work, do women have adequate access to family planning? If not, do you think that provision of injectable contraception by community-based paramedics is an effective and safe way to improve access?

Day 1 – Summary

Dear colleagues and friends,

Thank you for your rich and substantive comments – we are off to a great start!

As of this writing (Monday 20:00 h GMT), we have 267 participants representing 53 countries registered for the e-forum, “Addressing Unmet Need for Family Planning in Rural Areas: Introducing Community-Based Distribution of Injectable Contraception”. This level of participation is fantastic and shows that there is abundant global interest in this subject. We hope to hear from all of you over the course of the week and that the discussion will be beneficial to your work. Those who contributed to the discussion today were from Nepal, Pakistan, Afghanistan, Ethiopia, Nigeria, Kenya, Switzerland and the United States.

We realize that participants from the Africa and Asia regions may not have seen the Day 1 welcome email due to timing. It does not matter if you did not have a chance to participate on Day 1. You can start now with questions from the first or second day and answer any question (or pose new ones) where you wish to share your experiences.

Overall, more people favored CBD of injectables, or thought it had promise, than were against it. However, nearly all those who favored the idea of CBD provision of injectables felt strongly that several conditions needed to be met before it could be successful and safe.

First and foremost was training. Our very first respondent, KC Rashmi of Nepal, works in a CBD program and provides Depo Provera. KC felt that CBD of Depo is a good solution in the Nepalese context, but only “if paramedics are given adequate knowledge and skills based trainings on family planning.” Ketsela Kibret and Assefa Amenu of Ethiopia and Olukunle Omotoso of Nigeria made similar comments. We remind participants that both the [Case Studies](#) and the [Library](#) sections of the forum contain descriptions of recent training programs for community health workers providing Depo.

Another very common thread was that such programs need to carefully take local culture into account. A very thoughtful posting by Temitope Fadiya of Nigeria made it clear that CBD of injectables could never succeed in that Country without a “community entry approach” that facilitated the work of CBD workers while taking into account opposition of professional groups and the beliefs of rural dwellers.

Several respondents, including Jane Otai of Kenya worried about the dangers of syringes in the wrong hands, and, in particular, about re-use of syringes. That view was countered by Douglas Huber of MSH in the USA, who reminded participants that many programs now use autodisable syringes, which cannot be re-used. Huber also highlighted the fact that, in over 1,000 injections followed in Afghanistan, there were no infections reported.

The side effects of Depo and other injectables were also a concern for some respondents. Sefatullah Habib, whose program in Afghanistan includes CBD outreach of Depo, noted that many women discontinue injectable use after one or two injections because of the high rate of side effects. In the context of countries where the IUD has been largely replaced by Depo Provera, this phenomenon may explain some of the paradox noted by William Stones in Kenya, who described DHS data suggesting that use of injectables was associated with short birth intervals.

Responding to participants who felt that CBD of injectables was simply too dangerous and not worth the risks, Jason Smith (USA) reminded us that safety issues should not be seen in a vacuum. Rather, Smith says, safety of CBD of injectables needs to be examined in light of the risks of pregnancy and childbirth run by poor women with inadequate access to services.

Finally, we had a thought-provoking post from Shawn Malarcher at WHO. Shawn felt strongly that the forum was over-emphasizing rural dwellers, and that intensive service delivery approaches like CBD are needed “wherever there are large disparities in utilization of health services.”

We also want to encourage you to check out the [Library](#) for great resources on injectable contraceptives, single-use syringes, safe injection, waste management, and findings from countries with successful CBD of injectables programs.

As we move into the second day of the forum, we should build on the wealth of experience evident from today's discussion. Our participants cover a wide range of skills and geography, and on Day 2, we will draw upon that experience and apply it to lessons learned from recent interventions in Uganda, Madagascar, and Afghanistan. Summaries from these projects are found in the [Case Studies](#) link of the forum site.

Today's questions: Based on the three case studies, how well did these innovative projects work? How were challenges such as uptake, training, injection safety, supervision, etc. addressed? How can you relate these examples to your own experience?

We look forward to continuing the discussion and reading your comments. Enjoy your discussion, everyone!

Kirsten and John

Day 1 – Postings

Name: [Rashmi KC](#) - Thursday, May 17, 2007 - 10:44 PM **Country:** Nepal

I had been involved for promoting rural women's sexual and reproductive health for one and half years in the rural area of Nepal being a paramedic. There was one choice 'Depo-Provera (3 months injectable contraceptive)'. Though it was the only effective contraceptive they felt, it had some kinds of side effects, which were not treatable. It was very difficult for them to make another choice...

I strongly believe if the paramedics are given adequate knowledge and skills based trainings on family planning, it would be the best solution in the context of Nepal.

Name: [Sefatullah Habib](#) - Saturday, May 19, 2007 - 2:09 AM **Country:** Afghanistan

In the area we (Sanayee Development Organization SDO) work, the community has adequate access to family planning. We provide family planning through fixed health facility and outreach program (by Community Health Workers).

In our catchments area, a number of women refuse to get injectable contraceptive for the second and third time due to its side effects.

Name: [nousheen aijaz](#) - Monday, May 21, 2007 - 6:20 AM **Country:** Pakistan

i m working in field for family planning since 7years. i think it will not be safe coz as i have very bad experience about miss use of contraception by paramedics. it must be followed by proper training and monitoring.

Name: [ketsela kibret](#) - Monday, May 21, 2007 - 8:11 AM **Country:** Ethiopia

"Yes" if you want to do the job in large scale (achieve better access) community based distribution(CBD)of injectables seems to be the best methodology of doing it in resource constrained settings like that of Ethiopia. But I will also hesitate to recommend CBD of injectables when considering the "quality" aspect of the job. Especially when I think of the standard infection prevention techniques that are warranted to provide the service in hygienic manner.I think proper training and ongoing supervision of the CBD, with sustained & reliable supply of the injectables will always help achieve both quality and wider access to injectable contraceptives.

Name: [Assefa Amenu](#) - Monday, May 21, 2007 - 8:59 AM **Country:** Ethiopia

Whether we approve it or not injections are given by lay people in wider rural areas where accessing health workers is difficult because of geographic and financial barriers. If we can make sure all the injection safety precautions are ensured through training and frequent coaching why can't we have

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injectable contraceptives provided at the community level?

Name: Temitope Fadiya - Monday, May 21, 2007 - 9:19 AM **Country:** Nigeria

Introduction of certain health initiatives, products or commodity at the community level in certain African countries should be done with utmost caution. It must be noted with much seriousness that what is or has worked in certain African countries must still be introduced with much caution in others bearing in mind the sensitive nature of certain other countries in terms of the ethnic or cultural complexity of such environment.

In order to have a broader coverage of rural dwellers that might benefit much from the community-based distribution and approach to the use of injectable contraceptives, then there must be a proper community entry approach that would eventually lead to the acceptance of such commodities due to myriads of factors.

For instance, in a Country like Nigeria, an issue was well publicized in the dailies during the year 2004 when certain the government of certain states in the Northern part of the Country rejection the immunization of children with the polio vaccines. A laudable initiative which was meant to help prevent one of the devastating childhood illnesses was bluntly rejection in error due to ignorance. This is one of such example that really underscore the need to have a proper 'community entry' approach when certain initiatives must be introduced in certain society irrespective of the success stories already recorded in others.

Also, professional groups in certain African countries tend to be protective of their jobs and an attempt to introduce an initiative which would, as it were, witness other lay individuals being trained and use to perform such a function that be met with stiff resistance. They tend to see such initiative as being prejudicial to their interest and, as such, if such initiative or intervention must succeed then representative of all concern professional groups must be adequately sensitized and carried a long. Another good example is a situation where in certain Nigerian states a professional group bluntly refused the use of trained lay counsellors in the 'Counselling and Testing' services which has been decentralized in many countries and now been done at multiple testing points resulting in increased accessed to such services.

In addition, since the community based distribution of the contraceptive injectables would make use of volunteers who would be trained at the community level, then modalities must be fashioned out on how to continually sustain the motivation of these volunteers bearing in mind that they would not be remunerated. Motivating volunteer workers in resource-constraint settings has become an issue that must be looked into critically if certain health initiatives or intervention would be successful and a sustained local ownership of such initiatives would be ensured over time.

The involvement of community-based organizations would be highly beneficial in the CBD of injectable contraceptives in meeting the unmet needs of rural dwellers by helping in the area of referral and linkages. Referral and linkages of services of this nature is a major challenge in resource-constraint countries. The availability of these services at various locations within the local communities must be documented and, perhaps, a directory of all such community workers or groups providing such services must be well documented.

Name: Olusesan Makinde - Monday, May 21, 2007 - 9:49 AM **Country:** Nigeria

In providing such a practice, one has to be careful as there are a wide range of side effects related to hormonal contraceptives. Besides giving these injections, there are many pre application investigations that are suggested which may be unavailable to the care giver but which may be narrowed down by appropriately trained medical personnel. Though outcomes at studies may be impressive as a result of strict monitoring of activities of these care givers, these outcomes may not be the true picture in the real world. In as much as i agree that there is a problem with provision of these services, i would like to suggest advocating a better distribution of medical and nursing staff. In a Country like Nigeria, there is an inappropriate distribution of medical personnel which causes an acute shortage in needed areas. This still boils down to unavailable infrastructure and a lack of political will to put appropriate health facilities in place. In a Country where primary health care facilities are supposed to be provided in each ward or district and this is not available then there should be a focus at directing resources at putting up

such facilities with health posts related to these PHC's manned by trained nurses. Thank you.

Name: *Jane Otai* - Monday, May 21, 2007 - 10:12 AM **Country:** United States Of America

We received the following comment by email from of JHPIEGO/Kenya:

While I agree that the community based distribution of injectables could be a way out for communities in low resource settings, I would argue that they can truly be unsafe in slum communities that I work with. The reason for this is the risk of community members not being able to practice infection prevention while administering injectables and because of abject poverty, it would be easy for them to use one syringe for more than one person. In this era of HIV it would be quite risky to have community members provide injectables. Both the clients and the providers face the risk of other infections HIV included when practicing this

In addition the possibility of abusing the use of syringes is high. In slums drug addiction is rampant and criminals acquiring these syringes for illmotives cannot be ruled out.

Therefore even as we advocate for CBD Injectables care and maximum precautions should be considered.

Name: *Jason Smith* - Monday, May 21, 2007 - 12:46 PM **Country:** United States Of America

One notion that should be considered in a debate of this sort is "Safe compared to what?" Clearly CBD of injectables requires a certain level of organization of services, high quality service delivery and ongoing quality control mechanisms. But at the same time, both pregnancy and child birth carry risks, often quite high in rural areas of developing countries. I think we should remember that failing to provide access to quality family planning services may not be a "safe" option.

Name: *Douglas Huber* - Monday, May 21, 2007 - 2:44 PM **Country:** United States Of America

In Afghanistan, literate and illiterate community health workers (CHWs) gave injectables in remote rural areas. We did not encounter problems with infections or misuse of syringes for the roughly 1000 injections given. The auto-disable syringes worked well in preventing misuse, and we found no infections. I wonder what others have experienced with with the auto-disable syringes and injection safety?

Name: *William Stones* - Monday, May 21, 2007 - 3:14 PM **Country:** Kenya

By 'FP access' do we mean individuals getting a particular method, DMPA in this case, or do we mean access to the health and social benefits of spacing methods for individuals and communities? If the latter, I wonder if there is any information about relevant indicators of such benefit, eg an impact on child spacing arising from CBD of injectables? I raise the question because our analysis of African DHS data suggested that use of injectables was (unexpectedly) associated with increased odds of a short birth interval.

Name: *olukunle omotoso* - Monday, May 21, 2007 - 3:39 PM **Country:** Nigeria

Practically speaking injectables are not available in the communities (rural areas), this is due to so many reasons such as poor access, neglect, and the fact that attention of health professionals, policy makers, among others are not properly addressed towards them. Moreso, using community-based-distribution of injectables can be an effective and safe way to improving FP access if the community health workers are properly trained and monitored based on the cultural factors involved in the rural areas concerned. Thanks.

Name: *Shawn Malarcher* - Monday, May 21, 2007 - 4:19 PM **Country:** Switzerland

I am concerned about the overemphasis, in my opinion, on the utilization of CBD for rural areas. While poor, rural women might present the most compelling case for application of community-based distribution, I would argue that where ever there are large disparities in utilization of health services there is a need for a more intensive service delivery approach. I think we need to continue to emphasize the

role that CBD plays not only in the delivery of contraceptives, but also in linking disadvantaged populations to the health sector and health care.

Name: J. Rolando Figueroa - Monday, May 21, 2007 - 6:10 PM **Country:** El Salvador

No, definitely they do not have access to FP, but the issues concerning about the distribution chain of those supplies should be "guided" by very clear, objective, easy to follow, no misleading, simple, clean, transparent. safe storage recommendations, as well as to consider the huge distances some women need to walk in order to see one CHW. Also, the avoidance of possibilities of transmission of other diseases as well as complications at the site of the injections. That means a very well trained, able to provide some follow up CHW. Also, some CHWs used the provision of supplies to coerce people, that should be clearly stated in order to avoid these situations.

Name: Lionel Vigil - **Date:** Monday, May 21, 2007 - 6:35 PM **Country:** Peru

Women and men in the rural areas of Peru have not access to contraceptives because the health centers are not being supplied. For many years FP programs here have relied on international aid. Despite the fact that Peru's economy is performing well in the region, the government is not investing enough in health, the budget in health is lower compared to other countries in the region. However, contraceptives are available in all private clinics to which women from the rural areas cannot access because of poverty. I think CB distribution of injectables I would be an effective way to improve FP access in Peru, in my opinion it is the most practical way to break the vicious circle of health inequity. In order to do that human resources need to be allocated in rural areas since Peru has a good supply of medical and nursing professionals.

Name: ABDUL QAYOOM - Tuesday, May 22, 2007 - 2:35 AM **Country:** Pakistan

In Pakistan community based distribution of Family planning methods(only pills and condom) started in 1991, in 6 districts through pilot project. At the start of pilot activities the CPR was on average 6-9%. but within a period of 2 years (19993) increase in CPR between 30 -35 %. It proves that community based approach is very successful strategy to maximize access of FP services. But provision of injectable contraceptives through health care workers at the house hold level, need some serious consideration especially Country like us, where we have very little qualified / professionally trained staff, where literacy rate is significantly low (especially in women), where there is very little or know knowledge about side effects of FP methods (lots of myths and misconception) about FP, and the most significant problem is misuse of syringes. One of the major mode of transmission of Hep-B & C,/ HIV, through infected needles.

In presence of these challenges, one should be very careful about introduction of new initiatives.

Can some one like to address / respond to these concerns.

Name: nousheen aijaz - Tuesday, May 22, 2007 - 3:21 AM **Country:** Pakistan

in rural area of Pakistan great need of contraception, but we have to create awareness about side effect and misuse. it should be parallel to need full fill programs. we have to work first upon SWAT analysis in our community. I strongly believe that if we keep the threats and weaknesses in mind. we would make better and successful strategy. in Pakistan multiple community based programs running at this time. But still we have unmet need. That could be addressed by trainings of field staff with technical supervision in field.

Name: Baba Issa - Tuesday, May 22, 2007 - 9:34 AM **Country:** Nigeria

CBD is an effective way of improving FP access. However, facilities needed to achieve this would take into consideration the terrain and the culture of the people. Also, proper training of manpower on injection safety needs to be carried out.

Name: Kirsten Krueger - Tuesday, May 22, 2007 - 9:35 AM **Country:** United States Of America

Posted on behalf of Penina Ita, Director, AIDS Care Trust of Namibia

I live in Sub-Saharan Africa, Namibia, the land of the brave. I have strong challenges with the use of injectable contraception. What are the mechanism and strategies for the role-out including adherence to government guidelines? If there could be safer way of using contraception, why using injectable contraception? what are the benefit of Africans by using this dangerous regarded methods?

Name: Hilda Sekabira - Tuesday, May 22, 2007 - 10:11 AM **Country:** Uganda

I think with training, your fears can be addressed. However the training has to be tailored to level of the trainees. The training would also have to include safety precautions so that CHWs know what to do when accidents happen.

Name: ADEYEMI ADEKUNLE - Tuesday, May 22, 2007 - 12:21 PM **Country:** Nigeria

Training CBD agents to administer injectable contraceptives is one thing, ensuring that they adhere to infection prevention practices is another. Complications arising from poor infection prevention practices may not augur well for the entire FP program. The problem goes beyond training/education of the CBD agents: poverty is a major factor. These agents may want to cut costs and engage in malpractices with resultant catastrophic complications. But it really sounds as a fantastic way to create access if it works well.

Name: Jason Smith - Tuesday, May 22, 2007 - 2:23 PM **Country:** United States Of America

Use of any contraceptive involves trade-offs. When an individual makes decisions about contraception, ideally they should be well informed and consider how well the method is likely to work for them, how safe it is to use, whether or not the side effects will be tolerable, whether there are non-contraceptive benefits, and their access to the method including geography, cost, etc.

At a program level, planners should be asking them selves a parallel set of questions before they add any method to their services. Has the effectiveness of the method been demonstrated? what does the safety profile look like and is it appropriate for the population I'm trying to reach? Will the method be culturally and socially acceptable? Does providing the method make sense in terms of the other services already offered? Do I have the expertise and resources necessary to insure quality service delivery?

Injectables have well known advantages and disadvantages for users and for service providers. Interested readers can refer to the Library for details. Clearly, injectables may not be a method for every person or for every program and an inability to mitigate the potential disadvantages surrounding safe provision offer feature prominently in a decision not to provide the method. But global experience has clearly demonstrated that this contraceptive method and this means of delivering it, deserve serious consideration in efforts to improve health and improve options for women to determine their own lives.

Name: Ebissa Wakene - Wednesday, May 23, 2007 - 4:08 AM **Country:** Ethiopia

Strongly yes!, the number of women here in my Country who prefer injectable contraception is increasing from time to time. However, my experience is telling me that there is still shortage of supply in the rural area. Women in rural area are crying for injectable contraceptives.

In order to satisfy the demand, there should be a strategy "community-based distribution" to be implemented as early as possible. Ethiopia has started a Health Extension system that will contribute to this also. Other countries may learn from this too.

Thanks

Name: nousheen aijaz - Wednesday, May 23, 2007 - 4:15 AM **Country:** Pakistan

This community based distribution of contraception will definitely improve the quality of life and by access of contraception maternal mortality rate will also decrease. so there is need of collaboration between public and private sector. Because they both have working field force which could be utilize for this purpose and because the objective and goal is same that is :SAFE MOTHERHOOD: but for very serious and life threatening issues by the use of injectable must be address's. I think we should give

knowledge about hepatitis B:and hepatitis C. We should involve media at every level. I think the awareness about these health issue must be the part of school education's. We have to realize our responsibilities and fulfill them . the stakeholders could focus those areas where there is demand and avoid overlapping in the area where projects are running already.

Name: [folayinka akinpelu](#) - Wednesday, May 23, 2007 - 7:44 AM **Country:** Nigeria

I think the community-based distribution of injectables is a more effective and safe way to improve family planning, the only thing that needs to be given critical consideration is that of (a) properly trained health personnel;(b) proper education and awareness for the rural populace on the effectiveness of this method. It may initially be strange to them, but as time goes on with proper sensitization and proper monitoring, the method will eventually be accepted. The issue of safe motherhood and family planning is paramount in my Country, because of the level of poverty(many families have more no of children they could adequately cater for, and some of the previous methods may have failed them in the past, so introducing the injectables - i think will be safer for them and the risks and failure may be reduced by using this method.

Name: [Kirsten Krueger](#) - Wednesday, May 23, 2007 - 10:13 AM **Country:** United States of America

Posted on behalf of Laurent Munyankindi:

At first, in some countries i lived in, nurses used injectables than other methods. women want that method more than others, but we have some cases who cannot get pregnancy after severall years with DMP. sometimes we find infertility after only one or two injections. the women didn't changes husbands and hysteroigraphy shows good tubes with the opaque produce into the peritoneum cavity. then, can we encourage CBD? In my Country, I think we have enough healthcare centers to leave the injectables in professionals hands. If we don't do so, we will see so many abscess because low hygiene level.

Name: [Jully Chilambwe](#) - Thursday, May 24, 2007 - 5:29 AM **Country:** Zambia

I have been closely following this interesting discussion for the past three days and I have learnt so much from the case studies where this program has proved to be a success. Zambia is equally affected by the fact that women in rural areas find it very difficult to access family planning services as a result of distances that they must travel to the nearest health center, many of the rural health centers are understaffed and a lot of them are being run by untrained non medical personnel like Casual Daily Employees who are themselves overwhelmed. Under such situations, women are denied access to FP services. Community based distribution of Injectables would go a long way to increase access due to the fact that these CBDS are found where the services are needed, the CBDS know their communities better, some of them are Traditional Birth Attendants who have seen women pre pregnancy, through pregnancy, labour as well as postnatally. Don't we think they would be the best even to continue to offer FP services including an injectable? Like TBAs, all these people would need is intensive training and close supervision. Medical personnel were not such until after training. Equally a well trained CBD would function very well to safely administer an injectable. I would propose that the Pharmaceutical Regulatory Authorities give the injectable the status of OTC but controlled by the channel of Distribution Our Government needs to consent to this if we have to achieve our MDGs of reducing maternal mortality. The Donors should also fund such important projects which will enable us reach out to rural women with a high unmet need for FP

Name: [Anteneh Habtewold](#) - Thursday, May 24, 2007 - 6:55 AM **Country:** Ethiopia

My concern is on the effectiveness of the CBD model or programme arrangement. In this frame of thought, we need agree on what CBD means before deliberating on the effectiveness and safety of CBD of injectables. According to a report by FHI/PC, the typical CBD model was first tested in Asia and its use developed further in Africa and Latin America. In sub-Saharan Africa, CBD models have been used for over 30 years to provide family planning services. A typical model of CBD has been for local distributors (we call them CBD agents) to target married woman to offer information, temporary family planning methods (typically condoms, pills, and spermicides), and referral to clinics (in our case to outreach points as well) for more long-term methods or, more recently, for treatment of reproductive health problems. The same report further notes that, numerous alternative models have been shown to

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function effectively. The organization I work for, FGAE which is an affiliate of IPPF, pioneered CBD in Ethiopia. We call our model a COC model where a freestanding or a mobile Clinic of the Association and/or the Government, and Outreach point of delivery which is where most clients are referred to get the injectables and a CBD agent (with the above roles) collaborate to increase access to FP for communities/women in remote rural settings. The CBD agents are trained frontline volunteer workers. An array of motivation schemes including effort pays which are collected from costs shared by clients are employed to ensure sustained work of the volunteer agents. Recently, a creativity fund scheme is also proving to be an effective way of ensuring the sustainability of our CBD programmes. At present, we are applying this model in more than 800 peasant associations in most of which an increase of the CPR by an average of 40% is documented over a period of two to five years. The most profound success of the programme was changing the attitude of most conservative communities (by working on an array of barriers) as a result of which demand for family planning services was created.

The injectables were provided by Nurses or Health Assistants (HAs) at the outreach points. These outreach clients are referred by CBD agents and contact persons in addition to market place and work place agents. I am not sure what paramedics mean in our health service delivery context. In the medical university, all professionals below the MD/GP are labeled as paramedics according to my colleague.

In this model, medical safety is not a concern because it is provided by middle level medical professionals who are well trained, qualified and certified health workers. If I understand effectiveness to mean doing the "right" things (in its simplest form), then we need to discuss a whole array of issues part from its medical effectiveness. Particularly important in the examination of effectiveness are the different CBD arrangements (in the context of the above definition) that are in place in different settings. In Ethiopia now, the Government (re Health Extension Programme of the HSDP) is placing two trained full time salaried Health Extension Workers (HEWs) in every peasant association to provide a range of preventive health information and services including provision of injectables. These HEWs have one year of training. They received their training in a TVET setting by applying an industrial model of training. I am not sure whether we can call these paramedics or not. But, in terms of their certification, it is my understanding that they are below the Health Assistants who are below the Nurses in term of certification. They have got a certificate. In Ethiopia, the HA training is discontinued and most of the HAs are upgraded to a Nurse level (which is a Diploma qualification). I've got to go now but I want to continue discussing the issue in this context.

Name: Kirsten Krueger - Thursday, May 24, 2007 - 10:43 AM **Country:** United States Of America

Posted on behalf of Dr Robertine Randriasamimanana, Project Director NGO PENSER Madagascar

Greetings dear All, it is my first time to communicate with all of you on this Forum, our NGO worked since 2006 on Madagascar rural areas(10 communes), along the protected forest corridors that are largely inaccessible, lack of roads, floods or cyclones. We aim to reduce the inequities in FP access and also focusing on priority conservation areas in light of disappearing forest. We are on way to expand our sites in another 50 Communes with 297,000 FP users for the next two years. For the question on Day 1, the use of FP method injectables by CBD is a solution in our context, to give access to FP for the population in our area. With the case study shared by FHI Madagascar, it demonstrates the needs to be assessing before to scale up the CBD services to DMPA, it is very helpful for us for our strategy. The injectable is the favorite FP method for rural women in Madagascar. [Also see note in lessons learned thread.]

Name: John Stanback - Thursday, May 24, 2007 - 5:17 PM **Country:** United States Of America

Posted for Nandago Sylvia of Uganda

Dear All, I work in the South Western Uganda at Bwindi as Population Health and Environment Coordinator. Bwindi is home to the approximately, half of the world's estimated population of 700 mountain gorillas. The place is hilly, difficult to reach and people staying there are poor and their fertility rate is high. Population Health and Environment (USAID) funded our Organisation which is Conservation Through Public Health (CTPH) to start Community Based Family Planning linking it to the environment. We trained CBDs to distribute condoms and pills but during our monthly meetings we found out that the clients prefer CB Depo since we are having a CBDOTS programe running in the area. There are many family planning drop outs in health centres due to long distances. With support supervision, the CBDs

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can easily give injections without any problem. CB-Depo will benefit areas which are difficult to reach like people bordering Bwindi Impenetrable National Park and we will be able to preserve our environment by reducing on the population pressure.

Name: *ketsela kibret* - Friday, May 25, 2007 - 3:32 AM **Country:** Ethiopia

Yes, indeed! The organization I have been working for (FGAE) has proved for the last 3 decades that as long as community sensitization schemes through established CBD agents is there, community mobilization for injectable contraceptives will be no problem. Our FP clients at FGAE are already confronted with barriers of transport, finance and time. We clearly need to overcome these barriers somehow. I think the strategy of "community based distribution of injectables" is an alternative way out. But as I see the problem in our setting is more than that. We need to devise a better way of accessing our rural communities by working together with the ministry of health and other stakeholders in a more complementary & sustainable way. By this I mean there needs to exist a real national consortium of stakeholders of FP. The service has to be sustained at, as much as possible, the community level. But challenges of meeting the unmet FP need is magnificent simply because of unreliable and often seasonal national supplies of injectable and other FP commodities. For me the issue of sustained supply of injectables, and more decentralized (community based) supply of them plus improved supervision of the CBDs will lead to more effective and safe way of the CBD of injectables.

Name: *Chukwuyem Okoh* - Friday, May 25, 2007 - 1:04 PM **Country:** Nigeria

CBD of injectables would be more generally acceptable if they packaged in pre-filled, auto-sable, subcutaneous preparations. This reduces the skill required and chances of contamination while filling the syringes.

Day 2 – Discussion Thread

Based on the case studies from Uganda, Madagascar, and Afghanistan, how well did these innovative projects work? How were challenges such as uptake, training, injection safety, supervision, etc. addressed? How can you relate these examples to your own experience?

Day 2 – Summary

Dear colleagues and forum participants,

First of all, many, many thanks to all of you who have responded to questions posed in the first two days of the forum – and to several repeat contributors too. We're also very grateful for all the positive feedback and encouragement we have received in the past day on the importance and timeliness of this discussion. This means that the issue is relevant to the work of many of us and that the opportunity to learn from each other and exchange ideas is needed.

We had more great commentary today, from every corner of the globe (Africa, Asia, North and South America)! Though there was not total agreement about community based distribution of injectables, there was near-unanimity that access was a critical problem for poor women. This feeling was summed up by Oscar Nkatilo of Tanzania, who notes the many challenges, but says, "Do not deny access of our women to this family planning method; the evidence is there."

Responding to today's question about the injectable provision by CBD workers in Uganda, Madagascar, and Afghanistan, the comments, like yesterday's, focus on the importance of good training, cultural sensitivity, and community involvement.

Participants also ask very specific questions about some of the case studies. William Stones in Kenya wants to know about the costs of these projects and plans to sustain them, and Adeyemi Adekunle asks how the Medical and Nursing Councils in Uganda were convinced of the benefits of CBD of Depo Provera. Angela Akol in Uganda addresses both questions as they apply to Uganda. For the first question, she notes that the costs of adding injectables to an ongoing program are modest, since the CBD "infrastructure" is already there. For the latter question about buy-in from professionals' organizations, she explains that results from the pilot phase of the study were convincing enough to be used in advocacy efforts with the Nurses and Doctors before the eventual scale-up.

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We are also glad that participants continue to comment on yesterday's question as well. Abdul Qayoom from Pakistan provides strong evidence of the great potential of CBD, noting that the contraceptive prevalence rate in six districts increased by 30-35% in just 2 years, after the introduction of CBD of pills and condoms. He worries, though, about the misuse of syringes and the possible spread of infections such as hepatitis and HIV, and he asks other participants to respond to his concerns. Does anyone care to comment?

Another participant, Penina Ita of Namibia, was even more skeptical and wants to know how adherence to service delivery guidelines can be assured. Hilda Sekabira of Uganda responds that properly tailored training, including safety precautions, can address these fears. Adeyemi Adekunle of Nigeria also responds, but less positively, noting that, in spite of training, poverty might lead to dangerous shortcuts by providers. Note: In both Afghanistan and Uganda, it was found that the co-packaging of auto-disable syringes with Depo has nearly eliminated this concern. Syringes cannot be re-used, and CBD workers merely have to make sure that the injection site is reasonably clean, either with alcohol or clean water.

So thanks for the insightful, smart comments on the benefits and concerns of CBD of injectables and the numerous considerations to be addressed when considering implementation. We will continue to call on colleagues who have worked with CBD of injectables programs to comment on lessons learned and explain how the initiatives were launched and implemented in their countries. Now, we would like to take the discussion in a new direction: building support and momentum for the introduction of CBD of injectables.

The questions for Day 3 are: In your Country, what steps can be taken to overcome medical and political obstacles to introducing CBD of injectables? Which stakeholders need to be sensitized and supportive to ensure successful uptake of the intervention?

We're eager to hear your comments, questions, and experience on any of the questions posed on the forum so far. Please do not feel limited to responding to the question of the day. All discussion threads are open and we're looking forward to hearing from all of you!

Best to everyone,
John and Kirsten

Day 2 – Postings

Name: [oscar Nkatilo](#) - Tuesday, May 22, 2007 - 3:02 AM **Country:** Tanzania

It is possible to use CBD of Injectables, we should get rid of worries that injection is provided by only Health professional but still training should cover handling menstrual disturbances most women experience and INFECTION PREVENTION AND CONTROL MEASURES/INJECTION SAFETY. I find this is very crucial. This programme is visible to any Country, need to change our attitudes, Donot deny access of our women to this FPMETHOD, the evidence is there.

Name: [Baba Issa](#) - Tuesday, May 22, 2007 - 9:47 AM **Country:** Nigeria

Extensive training in form of institutional-based teaching and didactic lecture series are not the only way of training people on injectable contraceptive; a small but focused community health center-based training could go a long way in providing adequate knowledge to an effective CBD of injectable. In Nigeria the community extension workers (CHEWs) who are already practicing in the community and have gained the support and trust of the locals can assist, with little supervision, in training locals who would then form the bulk of personnel for effective distribution of injectables. This would enhance community participation as these workers are members of the community. This has worked with TBA (traditional birth attendant) training.

Name: [Hilda Sekabira](#) - Tuesday, May 22, 2007 - 9:54 AM **Country:** Uganda

Culture and religion play an important part in any intervention. I like the way the Afghanistan Project dealt with the cultural and religious issues which helped the health workers' and clients' acceptance of the different family planning methods. For instance the project related family planning to Islamic teachings and was able to get the Mullahs to talk about FP in the mosques and other religious gatherings.

Using dialogue with the communities is important as this builds the communities' capacity to handle their problems. Community dialogue was one approach a project in South Western Uganda used to help vulnerable adolescents cope with the challenges they faced regarding their reproductive health and it

was successful. The same approach can be used to deal with misconceptions that many people have about Depo and thus scale up CBD of DPMA in the rural areas.

Name: William Stones - Tuesday, May 22, 2007 - 10:20 AM **Country:** Kenya

May we know something about the costs of the projects, and plans for sustainability?

Name: ADEYEMI ADEKUNLE - Tuesday, May 22, 2007 - 12:31 PM **Country:** Nigeria

The findings of the Nakasonga Project in Uganda are quite interesting. But may I know how the Principal Investigators were able to convince the Medical and Nursing Councils of Uganda to allow CBD Agents to administer drugs parenterally? Was it a difficult task? I will like to learn from their experience. Thank you.

Name: Angela Akol - Tuesday, May 22, 2007 - 4:18 PM **Country:** Uganda

The results from the pilot study in Nakasongola were convincing enough for most of the 'sceptics'. Plus, the weighing in of the Ministry of Health was an important motivation for the nurses and midwives to change their perceptions. Initially the Nakasongola project was a pilot research project so buy in was not that critical. The scale up phase has involved advocacy meetings with stakeholders, which has helped to garner support

Name: Angela Akol - Tuesday, May 22, 2007 - 4:24 PM **Country:** Uganda

I agree, Baba. actually the Uganda experience has shown that for community initiatives classroom lecturing is not the preferred methodology. I attended some of these trainings and found that a lot of simulations and practicals are used, which the community health workers found very useful for learning.

The question of community involvement is also critical. It is important that the community workers are selected by the community and that they already have a good reputation. The Ugandan CHWs are actually selected by the community using predetermined criteria

Name: Angela Akol - Tuesday, May 22, 2007 - 5:03 PM **Country:** Uganda

In answer to Mr. William Stones, the costs of adding Depo to a CBD program are basically the costs of training the community health workers to give Depo - something in the region of 15k, depending on contexts. This is because an already existing CBD program will have catered for other items like job aids, incentives, etc. This reinforces the Nigeria idea that it is essential to work with an existing CHW program.

Sustainability is more challenging. The ideal situation is to integrate CBD of Depo into existing Ministry of Health community initiatives - this is why the MoH needs to be fully on board from the start. Uganda is mapping community based initiatives Country wide with this in mind.

Name: Lionel Vigil - Tuesday, May 22, 2007 - 5:21 PM **Country:** Peru

There has been a lot of objection from the biomedical point of view to CB interventions not only in FP but in all health programs. The evidence shows that providing adequate training, injection are as safe as any other noninvasive medical procedures.

The social determinants of health approach in public health has proved as well that a lot of change can be done if we trust in CB approaches and interventions. If we really want to change current situation of inequalities in global health we should create new conditions to implement health services, that is programs to serve the excluded population from the bottom up, because the top bottom approach has proved to be inefficient and unable to change the lives of people. Only by increasing local knowledge and empowering people to take control of their own needs FP intervention can be regarded as safe. The question I should have asked from the beginning would have been. How are the ones that define what is safe for whom. Are the ones who are at the bottom or are those who don't believe that the poor have the right to take control of their own needs?

Name: Douglas Huber - Wednesday, May 23, 2007 - 2:36 AM **Country:** United States Of America

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Sustainability for the Afghanistan project is partly ensured by the fact that community provision of injectables, pills and condoms is part of the national Basic Package of Health Services. The NGOs and ministry of health provide ongoing injectable services. CHWs are unpaid volunteers in Afghanistan. We found that special efforts were needed to coach and upgrade their skills, especially in counseling and managing common non-harmful side effects. The national program now employs CHW supervisors who give ongoing supportive supervision, although at a modest level in some areas.

Sustainability for written household-level information on injectables and pills is easy, as the cost was \$0.04/household to give this practical information. Other NGOs are planning to replicate such efforts with their own resources. Providing simple signs designating Health Posts (the CHWs' homes) was popular and inexpensive (\$2/CHW). This was extended voluntarily by the three NGOs to other sites.

Name: Kirsten Krueger – Wed., May 23, 2007 - 10:01 AM **Country:** United States Of America

Posted on behalf of Professor Japheth Mati - Kenya:

You'll forgive this next comment coming late in the forum: I enjoyed reading the three case studies; they clearly show there is potential of expanding access to injectable contraception through CBDs or CRHWs. What I found lacking was the description of background education of these 'paramedicals'. I think it is important to attempt to standardize the minimum selection criteria that include educational background.

Name: Martha Bekiita - **Date:** Wednesday, May 23, 2007 - 11:19 AM **Country:** Uganda

In Uganda. we set a criteria for selection for CBDs which is:

Education standard minimum of p.7 and above respected person in the community who is trainable and interested in family planning. The list is long i will give more information tomorrow. Regards, Martha

Name: Kirsten Krueger - Thursday, May 24, 2007 - 10:45 AM **Country:** United States Of America

Posted on behalf of Dr Robertine Randriasamimanana, Project Director NGO PENSER Madagascar

The main step taken for FP Project in Madagascar is that our President is involved in and through the Madagascar Action Plan. There is the challenge for implementing highly successful FP and a priority to ensure the application of agreed quality standards procedures for FP services at all levels. All Health workers and CBDs will be sensitized and be carefully on the syringes management. The big challenge for us is the availability of products at key distribution points.

The opinions expressed herein are those of me. Best regards to everyone.

Name: Martha Bekiita - Thursday, May 24, 2007 - 11:45 AM **Country:** Uganda

Dear colleagues, I wish to share my experience about CBD program, particularly with Depo provera provision. First and foremost, the community should be well prepared through community sensitization meetings, create demand for family planning services and then set selection criteria. The community is involved in setting the criteria. We explained to the community the work of CBDA/CRHWs were expected to do and the type of training they would under go, then asked the community to tell us the qualities of a person that would do the work. This is what came out as our criteria: 1. A mature female or male, above 18 years of age 2. Education- primary 7. and above, able to read and write. 3. Respectable and a resident in the community 4. Trustworthy and keeps secrets. 5. Interested in Family planning, and willing to work as volunteer. 6. Knowledgeable and trainable. 7. Polite and approachable 7. Clean 8. Does not drink or over drink alcohol and above all 9. This person is selected by the community.

Training The initial training is done in phases, the first phase is 5 days and covers the basics of family planning, introduction and concept of family planning, Technology of FP methods, Second phase of 5 days covers; communication process, IEC, counseling, home visiting, referral system and records and reports.

Post training - They work for 3- 6 months in the community providing oral pills, condoms, and making referrals to the health facilities, they refer for long -term methods i.e Norplant, IUD, Depo provera and permanent methods. During this time the supervisors closely monitor, give support and assess their performance. We set a selection criteria for depo provera training. CBDs/CRHWs who register many

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effective referrals for depo provera, and long-term methods are selected. The depo provera training takes two weeks, one week is for theory and practicing how to give injections, they do simulations using tomatoes and oranges. they learn; injection sites but restrict them to using one site and that is the upper outer part of the arm, drawing depo provera from the bottle maintaining aseptic technique procedure, hand washing before and after the procedure, Practice screening clients using checklists ,one for ruling out pregnancy and another one for eligibility. Week two, they go to the health facilities to work on real clients, They first observe one injection given by a health work. We set clinical training objectives which include; Each participant should: Conduct at least 3 group education talks, counsel at least 5 clients, give 5 injections, and complete 5 client's records. Trainers and health facility staff supervise participants while they carry out tasks using skills assessment tools. At the end of the training CRHWs are given 10 doses of depo provera, 12 auto disable syringes, some cotton wool, soap for hand washing, and safety box. Those who do not achieve the clinical objectives are sent to their relevant health units and helped to complete. Support supervision - Save the Children employs field supervisors, one supervises 10 -12 CRHWs, at the same time CRHWs are linked to their nearest health facilities where they get supplies from. every month they meet with their supervisor and health workers at the health facility, in the monthly meeting CRHWs submit report to supervisors, receive supplies, and check the referrals. When safety box is full the CRHW takes it to the health facility for burning and gets another one. I will continue tomorrow Thank you.

Day 3 - Discussion Thread

In your Country, what steps can be taken to overcome medical and political obstacles to introducing CBD of injectables?

Which stakeholders need to be sensitized and supportive to ensure successful uptake of the intervention?

Day 3 Summary

Dear all:

Here's to another rich and active day! The discussion is really gaining momentum and we clearly have a lot of expertise amongst us given the excellent ideas and questions on all the discussion threads.

First, one note to keep in mind in order to facilitate a fruitful discussion: Instead of replying to the daily email, please reply on the forum site. This allows you to stay current and enjoy the comments of others as well as ensure that the group can identify the author and Country associated with each comment.

Now, let's get on to business – with numerous posts from at least 11 countries, we noted that several new contributors agree that CBD of injectables is safe and effective and as Nousheen Aijaz of Pakistan says, it could “definitely improve the quality of life and ... [the] maternal mortality rate will also decrease. “Women in rural areas are crying out for injectable contraceptives,” says Ebissa Wakene from Ethiopia.

We also saw some great participant-to-participant discussion in the lessons learned thread. Experts from both the Uganda and Afghanistan programs share details about how cost and sustainability is managed in those projects. Working with a strong, existing CBD program where health workers are volunteer or compensated already and capitalizing on commodities supplied by the national program, helps to keep costs low for adding injectables to the method mix.

The primary expense in both cases was the specialized training to upgrade skills, particularly counseling for common, non-harmful side effects. Professor Japheth Mati of Kenya had a question about the selection criteria for CBDs, particularly the educational background. For Uganda, Martha Bikiita explains that CBDs must have completed 7 years of primary school. Martha promises more implementation details to come.

In the 'overcoming obstacles' thread, nearly everyone who responded today offered excellent ideas for whom to target and how to do it. Key stakeholders include: future clients, communities, politicians, providers, religious leaders, medical associations, regulatory bodies, pharmaceutical companies, donors, NGOs, government personnel at all levels, and training institutions. Sensitization and education were mentioned by many of you as critical activities for overcoming resistance, myths, and misconceptions. Other early steps suggested were assessing current regulations; identifying potential partners to assist with stages such as planning, advocacy, implementation, monitoring and evaluation; and ensuring adequate infrastructure and human resources.

Launching a CBD of injectables program can be done by using evidence from the successful implementation from other countries and by starting with a pilot project to generate findings to be taken to scale. Njeri Mukoma from Kenya, who participated in an educational tour of the Uganda program, says that “...focus on results rather than

process so positive results go a long way towards gaining support from all stakeholders". Early involvement of the government is critical as Mathew Tambukwa from Tanzania pointed out that after he became convinced of the efficacy of CBD of injectables in 2005 he found that MOH was not ready to learn about or support its introduction in the Country.

Job security was mentioned by several of you in relation to medical opposition. It was pointed out that it is important to assure trained providers that they will still keep their jobs and that CBD of injectables frees their time to focus on more serious medical cases. Another creative solution raised today was declassifying Depo Provera from a prescription to an over the counter drug combined training non-medical personnel to safely administer injectables.

Most of you who expressed concerns about CBD of injectables seemed to worry more about injection safety than about screening for contraindications. That's not surprising—projectin-only injectables such as Depo Provera contain no estrogen and have fewer contraindications than pills, which have been distributed by CBDs for years with few problems. In any case, checklists and other screening tools exist and are already used in many programs for safe provision of both pills and injectables.

Similarly, while you had some concerns about CBDs' ability to manage side effects, injection safety seemed more important to you. Again, not very surprising. Injectables are the most popular method in many countries, so most CBDs and their clients are already familiar with the sometimes bothersome side effects of this method, and clients with side effects can always be referred to clinical services.

If screening and side effects are manageable, why not injection safety? The first step, eliminating re-use of syringes, could end our fears of CBD workers spreading HIV, hepatitis, and other infections. Happily, that step is already being taken in many of your programs by supplying injectables with non-reusable autodisable syringes. In Afghanistan and Uganda, where thousands of injections by CBDs using autodisable syringes have been followed up, infections and abscesses have not been a problem at all.

The next step, to arrive in a year or two, is a new subcutaneous formulation of Depo Provera called Depo-subQ. Depo subQ provides the same excellent efficacy as the original Depo (with a lower dose of hormone), and is administered subcutaneously using a shorter needle than that required by intramuscular DMPA. More importantly for its use in developing countries, Depo-subQ will be supplied in the easy-to-use, pre-filled, non-reusable <http://www.path.org/projects/uniject.php> Uniject injection device.

In Latin America, CBDs already use this Uniject device to provide the combined monthly injectable Cyclofem. In fact, researchers there have found that women can safely give themselves contraceptive injections with Uniject, just as some diabetics give themselves daily injections.

Today's thread is a discussion of these new technologies and their role in spreading CBD of injectables:

- In your Country, are autodisable syringes being used?
- Will they help overcome objections to CBD of injectables, or do such objections have more to do with clinicians' status than paramedics abilities?
- Will future CBD workers merely furnish women with their Depo subQ, which women will inject themselves?

We urge you to add your voice to this discussion, while welcoming you to continue all three earlier discussions.

- John and Kirsten

Day 3 – Postings

Name: J. Rolando Figueroa - Tuesday, May 22, 2007 - 6:23 PM **Country:** El Salvador

Without going into much detail, the influence that some churches, especially the catholic church has on the politics of reproductive health in most of Latin America (maybe in all of it), and specifically in family planning services the challenge is to make them aware, informed and educated that many times is better to prevent a pregnancy than to deal with the death of a girl or a woman due to complications that arise during pregnancy, labor, delivery or postpartum. The issue here is how to find the links of inequalities for women, lack of services, and deaths of women and their children because of a policy dictated by few (mainly men).

Name: gordon perkin - Tuesday, May 22, 2007 - 6:41 PM **Country:** United States Of America

There are several ways that obstacles can be overcome when addressing the CBD of injectables. Recent advances in DMPA formulation have enabled the manufacturer to reduce the dose from 150 mg to 104 mg and to administer the product subcutaneously rather than as an intramuscular injection. Efficacy remains the same while administration becomes much easier since a much shorter needle can be used. When these advances are combined with Uniject (a single use prefilled injection device) it makes it very feasible to take the method from the clinic to the community. A woman living in the community can be trained in less than 15 minutes in the safe administration of DMPA /SC in Uniject. One woman in a village can become the "Depot" holder, administering the SC injection to her neighbors every three months. These improvements and innovations should enable the advantages of injectable contraception to be extended to many women living in rural communities who have not previously had access.

Name: sugiri syarif - Wednesday, May 23, 2007 - 12:51 AM **Country:** Indonesia

the most priority to be advocated is the head of the administration from the district level down to village level. After that is the religious leader. They should know that the injectables are not against the religious belief. Beside that, preparing the midwives or medical doctor the right information about injectables is also very important

Name: Angela Akol - Wednesday, May 23, 2007 - 1:24 AM **Country:** Uganda

In many cases the medically trained fraternity are a huge obstacle - we generally tend to feel that community based distribution of injectables is taking work from us. One way of handling this is to involve other community resources e.g. private midwives, drug shops where they exist in the community. Otherwise, we need to help medically trained people to realise that rather than taking our work from us, community based distribution is making loads at the health centers lighter and is meeting a need (even a human right) of underserved women.

Name: Ebissa Wakene - Wednesday, May 23, 2007 - 4:22 AM **Country:** Ethiopia

Organizations working on FP should work together on Advocacy. The type of the advocacy work might not require strong effort because it is understood by the government of most of the countries in the world that it is their issue too.

Name: Baba Issa - Wednesday, May 23, 2007 - 4:32 AM **Country:** Nigeria

Emphasis should be to education of would be beneficiaries. Make it part of PHC.

Name: Saul Walker – Wed., May 23, 2007 - 4:39 AM **Country:** United Kingdom (Great Britain)

May ask if there have been obstacles in any of the countries in which CBD has been piloted relating to product registration designation (i.e. injectables as prescription only products) and any restrictions over who can/cannot administer different types of service. Have regulatory authorities been involved in discussing the design of pilots, both in terms of objectives and for any temporary exemptions needed to run the pilots?

Name: Angela Akol - Wednesday, May 23, 2007 - 7:04 AM **Country:** Uganda

I know in Madagascar the regulatory authorities have moved rapidly to alter policy guidelines to facilitate injectable provision at the community level. In Uganda the regulatory authorities were involved and they okayed it as a pilot, the results from which would inform policy alteration.

Discussions on declassification of DMPA are also needed in Uganda because whereas the regulations define it as a prescription product, it is widely available 'over the counter'. The solution is to help non medical people administer injectables safely rather than try (unsuccessfully) to clamp down on drug shops selling DMPA

Name: ABDUL QAYOOM - Wednesday, May 23, 2007 - 7:59 AM **Country:** Pakistan

In order to overcome medical and political obstacles to introducing CDB of injectables, following steps can be taken into consideration: 1. Human resource development(training) of health workers / field force for provision of safe injectables. In Pakistan we are having sound infrastructure of these workers. 2. Advocacy on safe injectable contraception, at all level (policy, program and community). 3. Provision of auto-disable syringes (to discourage the misuse / re-use) of syringes. 4. Community education on FP methods to overcome the myths and misconception about FP methods, especially about injectables. I think the above mentioned steps could further help in promoting / delivering of safe injectable methods through community based approach.

Name: Kirsten Krueger – Wed., May 23, 2007 - 9:53 AM **Country:** United States Of America

Posted on behalf of Jasintha Mtengezo:

Step1- communicate with the Ministry of Health by writing the proposal in terms of - situation analysis, gap, how to address that gap and who will benefit. (selling your idea).Also sustainability of the interventions. stakeholders that need to be sensitised are all that are involved with health issues and regulatory bodies e.g. Nurses and Midwives Council of Malawi Medical Council UNICEF USAID SAVE THE CHILDREN Family Health International Training institutions etc

Name: Kirsten Krueger – Wed., May 23, 2007 - 9:57 AM **Country:** United States Of America

Posted on behalf of Jane Otai from JHPEIGO-Kenya:

In relation to the question for the day, the first group of people to be sensitized on the CBD of injectables are the Trained health providers/medical staff. The Trained health providers in the Kenyan context need to be sensitized because they could be a barrier to the CORPS providing injectables. You should realize that for many years Kenya has trained nurses and they have not been able to deploy/post them to health facilities due to various reasons. In addition, a number of health providers have been retired and are currently unemployed. There is likely to be an argument that these are the people who should be updated and given the task of handling injectables other than the illiterate, civilian and unqualified community health workers. Without proper sensitization of the trained health providers and assuring them that they will still keep their jobs with this development, it will be difficult for the CORPS to offer injectables in the community.

Jane

Name: Kirsten Krueger – Wed., May 23, 2007 - 10:00 AM **Country:** United States Of America

Posted on behalf of Professor Japheth Mati - Kenya:

Dear Colleagues,

Regarding Day 3 question, I think in Kenya there are likely to be at least two related concerns- permitting non professionals to give injections, especially away from close supervision by qualified persons; and the fear that the CBD so empowered may decide to apply the skill and freedom in other aspects of medical treatment, e.g. giving other injectable medications. The above concerns are likely to be raised by medical professionals- the Kenya Medical Association, Kenya Obstetrical and Gynaecological Society, the National Nurse Association of Kenya, and perhaps the regulatory body- the Medical Practitioners and Dentists Board. All these require to be sensitised and to be brought on board.

[See comment in Lesson Learned thread also.] Best wishes, Japheth Mati

Name: Kirsten Krueger

Date: Wednesday, May 23, 2007 - 10:02 AM **Country:** United States Of America

Posted on behalf of Nasreen Khan - Pakistan:

Dear organizers

I worked for Family Planning Association of Pakistan (FPAP), for more than 15 years in various capacities including head of CBD project. Following is my experience from Pakistan

In your Country, what steps can be taken to overcome medical and political obstacles to introducing CBD of injectables?

In Pakistan, medical and political obstacles are two different categories:

I conducted a research on "Determinants of RH service provisions among General Practitioners in Pakistan" and found that most of GPs are not trained in family planning. Therefore biggest obstacle is human resource development. Our medical school curriculum does not cater FP in teaching and after medical schools; there is no culture of continuing medical education for doctors in Pakistan.

Second medical obstacle is availability of human resources especially in rural areas and especially female service providers. Due to cultural reasons women want to visit female providers and they are a rare in rural areas. Third medical obstacle is attitude of service providers towards FP services. FP services are low in priority as they take longer for counselling and are less paying. service providers would like to do antenatal care and deliver a bay rather than giving injections

Among political obstacle, religion is biggest challenge. Each politician is worried about his constituency voters not turning against him on religion.

Â Which stakeholders need to be sensitized and supportive to ensure successful uptake of the intervention?

Among stake holders we need to advocate politicians, religious leaders and medical community to understand the graveness of issue and work with us.

Nasreen Khan

Name: Kirsten Krueger - Wed., May 23, 2007 - 10:06 AM **Country:** United States Of America

Posted on behalf of Godfrey Nkhoma - JHPIEGO -

1) Study of local policies. Some countries won't allow non medicals to touch syringes and prick people unless satisfied they are properly prepared for such activities. 2) Advocacy to generate interest for the gate keepers, evidence must be shown from other countries closer to our countries with similarly cultural and social economic background. How it started, progress made and how sustainable it has been to-date. 3) Stake holder analysis which could partner with you in advocacy, planning , implementation, M & E and close out. The stakeholders for Malawi could be: JHPIEGO, FHI, BLM, FPAM, NAC, MOH, CHAM

Name: Kirsten Krueger - Wed., May 23, 2007 - 10:07 AM **Country:** United States Of America

Posted on behalf of Njeri Mukoma - Kenya:

Political and medical obstacles can be overcome through advocacy using best practices from other countries especially in the region, with focus on acceptability and safety. The advocacy should initially target the Medical fraternity through their professional associations and regulatory bodies, including pharmaceutical companies as these are the most likely sources of discontent.

Having participated in a study tour of the Uganda CBD DMPA project, the political and legal concerns were addressed by adopting a "research" approach for the pilot, which took care of ethical and legal concerns therefore giving little room for political "disruptions".

A similar approach could be used in Kenya, and the results would be used to start the process of policy review; The Kenya National health sector strategic plan II identifies one of the key approaches as focus on results rather than process so positive results would go a long way towards gaining support from all

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stakeholders.

In Kenya, the community (or level one as is popularly known) is recognized, in the RH policy documents as the focus for health interventions; therefore the sensitization process should start at this level. The other stakeholders are mainly the government through the Ministry of health, and lastly the other key players in RH mainly donors, NGOs, etc.

Name: Kirsten Krueger - Wed., May 23, 2007 - 10:10 AM **Country:** United States Of America

Posted on behalf of Mathew N. Tambukwa - EngenderHealth - Tanzania:

Thank you for spearheading this discussion. Also for generating these important and practical questions. Participants do accept the need to introduce CBD of injectables which I also do. Much of the steps required for the introduction includes (i) Sensitization and mobilisation of medical professional bodies, Ministry of Health and Social Welfare, Service Providers and Community All the levels/steps mentioned above are important. Medical professional bodies can block introduction of the CBD of injectables unless they are involved from the start, likewise nothing can go on without the Ministry of Health. In 2005 I attended dissemination meeting in Uganda about Depo provision by the community reproductive health workers. The dissemination meeting was very convincing, I left the meeting converted and eager to lobby for the same in Tanzania. It never took place as I found the MOH was against the intervention and were not ready to hear not even discuss the possibility. The importance of service providers and community in this intervention is very prime, no more emphasis one can put here. (ii) I suggest a pilot study conducted within a respective Country with an assistance from external organisation will do. Presenting findings from within do increase acceptance and reduces sense of being imposed or otherwise. In this case a district which has active CBD program conducts a pilot of CBD for injectables and share the outcome with the larger audience in the Country. (iii) From the step above, lobby for adoption/adaptation can be done from within the Country. (iv) MOH and Social Welfare can then be in a position to prepare guidelines or policy for the same. It sounds long but in many of countries its very important steps for success.

Name: Hilda Sekabira - Wednesday, May 23, 2007 - 11:16 AM **Country:** Uganda

I concur with Matthew about the steps. A lot of lobbying and sensitisation has to be done for the intervention to be accepted.

A successful pilot project is important in convincing the various stakeholders that CDB of DPMA really works. In this the community really does play a key role as they will speak about the advantages CDB of injectables in their meetings and political gatherings. One you have the community on your side, lobbying the other stakeholders becomes easier.

About the medical obstacles there are risks in everything we do. In this case we are dealing with CHWs some of whom are not educated. Accidents will happen but with continuous sensitisation, a good referral system in case of side effects, careful M&E and supervision by community leaders, Professional health workers, district health inspectors, the medical regulatory bodies the obstacles can slowly be overcome.

It is also important to start at a small scale and scale up as the resources allow.

Name: John Stanback - Wednesday, May 23, 2007 - 5:34 PM **Country:** United States Of America

Posted on behalf of Prof Sydney Adadevoh of Ghana:

In Ghana, CBDs have been involved in the distribution of contraceptives, excluding Injectables, for some years now. Nurse/Midwives have been trained in Life Saving Skills and Emergency Obstetric and Neonatal Care (EmONC). The National Reproductive Health Policy and Standards (NRHSP-S) thus permits this category of Health Workers to administer injections. This does not include CBDs.

A revision of the NRHSP-S will be necessary to introduce CBD of injectables The unacceptably high Maternal Mortality Ratio (MMR) due to high parity resulting from lack of IEC and access to contraception among other factors - (214/100,000 live births is the accepted figure for the Country, but higher figures have been given by some organizations such as UNFPA & IMMPACT). The economic, social and community/ family impact of this high MMR should be strongly emphasized and given high publicity than

is the case presently compared to other disasters.

In addition, the high Neonatal and Infant Mortality Rates should also be quoted to support the points/arguments for the need to introduce CBD of Injectables.

The selection criteria of CBDs should be stringent. Only the best, conscientious and hardworking should be selected and given Clinical Skills Training in injection techniques, in particular in quality assurance: Infection Prevention & Control. A change/revision of the NRHSP-S is necessary in this respect.

The question of Abuse of the acquired skill is a reality, which cannot be overlooked given the lack of education, information, communication, ignorance and the prevailing poverty in the rural community, in particular. What can then be done to prevent and preempt abuses?

The Stakeholders should include:

1. Government: Govt Interest and Will is most essential.
2. Policy makers and Implementers in the Health Ministry, Departments and Agencies (MDAs), Health Care Managers and Service Providers at the various levels of the health care delivery system
3. District: district assemblies and their various organs: District Chief Executives and assembly members
4. Community: Chiefs, Queen mothers, Elders and Opinion Leaders, Community Health Volunteers, Women groups. Male Involvement is very crucial
5. Hospital administrators: District Hospitals and Health Center administrators
6. Medical and Nursing Schools; in particular, Heads/Chairpersons of these institutions
7. Identifiable advocacy groups such as Planned Parenthood Associations, Social Marketing Foundations/Associations etc
8. NGOs involved in Family Planning such as EngenderHealth, IPAS etc

Name: Chukwuyem Okoh - Wednesday, May 23, 2007 - 7:55 PM **Country:** Nigeria

Overcoming medical and political obstacles to CBD of injectables in Nigeria would require well designed policy advocacy. Obviously, it is doable. The most important thing is to use appropriate strategies to secure the support of relevant stakeholders. There have been similar initiatives involving such fringe practitioners as Patent Medicine Vendors (PMVs) or Traditional Birth attendants to improve access to health interventions. One such intervention undertaken by the BASICS project (USAID-funded) in parts of Southeastern Nigeria, involved improving capacity of PMVs to provide effective first line anti-Malaria treatment for children; as well as providing relevant linkages with sensitized community groups to help monitoring. Stakeholders that would need to be sensitized to ensure successful uptake of the intervention include Governments (Health authorities) at various levels, professional associations of Doctors, Nurses and Pharmacists, and community-based groups.

Name: Sefatullah Habib - Thursday, May 24, 2007 - 2:25 AM **Country:** Afghanistan

In our Country the following two steps are vital to In our Country the following two steps are vital to overcome the obstacles

1-Developing of the community awareness, Community awareness can be developed through health education, media, posters and seminars. 2-Training of the female community health worker

Name: ADEYEMI ADEKUNLE - Thursday, May 24, 2007 - 6:27 AM **Country:** Nigeria

One major obstacle to an effective CBD Injectable program in Nigeria is the lack of or weak/ineffective referral system. There must be an effective referral linkage between the CBD Agents on the field and the SDPs that may attend to side effects (mainly bleeding disorders) of injectables. A pilot study in this Country (especially where there is a strong referral system) will be quite interesting. I believe that the concern with regulatory bodies can be addressed through a strong advocacy.

Name: Kirsten Krueger - Friday, May 25, 2007 - 1:45 PM **Country:** United States Of America

Posted on behalf of Aminu Mohammed Hussain - Nigeria

To overcome medical and political problems relating to CBD injectables in my home Country Nigeria, the following suggestions may be useful: 1) more funding 2)workshops/seminars 3)continous training(on job) 4) ways to pave for acceptance of the CBD to be designed. Thank you.

Day 4 – Discussion Thread

Today's thread is a discussion of new technologies and their role in spreading CBD of injectables:

In your Country, are autodisable syringes used?

Will new technologies such as autodisable syringes and Depo subQ (see Forum Today) help overcome objections to CBD of injectables, or do such objections have more to do with clinicians' status than paramedics abilities?

Will future CBD workers merely furnish women with their Depo subQ, which women will inject themselves?

DAY 4 - Summary

Dear colleagues and friends,

Quite an interesting online discussion on CBD of injectables we are having! Once again, thank you all for sharing your comments and experiences with the group. Before we move to today's summary and questions for tomorrow, we would like to ask for your feedback on the forum. Kindly take a moment to complete the [short evaluation form](#) on the [evaluation](#) link which is located on the upper left-hand side of the website. We appreciate your opinions and suggestions.

Today's discussion saw a lot of thoughtful responses to the question about new technologies. Although all Depo Provera donated by USAID is supplied with autodisable syringes, several of you commented that these AD syringes are not widely used or that they are currently being introduced and used for immunization initiatives only. There was general agreement among contributors that both AD syringes and the new subcutaneous formulation of Depo Provera (Depo subQ) would be very welcome and would certainly help the uptake of CBD of injectables. As Baba Issa from Nigeria says, "This would go a long way at overcoming some of the obstacles expressed..."Several of you aptly noted that sensitization, training, a secure commodity chain, and client follow-up are needed even if new technologies, like self-injection become available. Julie Wiltshire from Uganda reminds us of the challenge of maintaining well-supported CBD programs in general. She explains, "...CBD programs are not uniform across the Country; some are well-supported and some are not and this will need to be taken into consideration for any efforts at bringing new technologies to the community."Another important considerations mentioned today is the potential benefits to clinic-based providers whose workloads are reduced when CBDs provide routine family planning.

We were very pleased to hear today from program managers such as Dr Robertine Randriasamimanana of Madagascar and Martha Bekiita of Uganda who shared details of their CBD programs and the clients' desire for injectables. Martha Bekiita cited crucial details about how CBDs who provide injectables were selected (by their communities), trained and supervised.

Many of you have mentioned the importance of close linkages between CBD workers and existing clinical services. Such linkages are always crucial, but even more so when paramedical personnel are providing injectables.

First, local clinics are the primary referral point for clients with contraindications or serious side effects. A good relationship between CBDs and the clinic staff will ensure smooth referrals. CBDs should always be encouraged to approach clinic staff when they have problems or questions.

Second, CBDs need a regular source of supplies, not only for injectables and syringes, but also for pills, condoms, and other products they provide. Even if CBDs work for an NGO such as Save the Children, public sector facilities may be the ideal "supply depot."

Third, particularly for public sector CBD programs, clinics are an ideal supervision point for CBDs. Trained nurses and midwives are well-placed for both the administrative and problem-solving aspects of supervision. Ideally, with CBDs managing much of the routine family planning care, clinically-trained personal would have the time both for supervision duties and non-routine patient care.

Finally, many women who get pills or injectables from CBDs really need longer term contraception, but have trouble accessing it. In the Uganda pilot study, a quarter of the CBD clients wanted no more children and would have preferred a long term or permanent method. Even when IUDs, implants, and sterilization services are unavailable locally, CBDs can advocate for such women and help arrange referrals and transport to higher level facilities.

Which brings us to the Day 5 questions:

In your Country, could CBDs link with public sector facilities for supplies and referrals? How would clinic-based providers react to such an arrangement?

How can CBDs help women access long term and permanent methods that are unavailable locally?

Friday is the last day of the forum. Happy reading and responding...

- Kirsten and John

Day 4 – Postings

Name: [fredrick ochieno](#) - Thursday, May 24, 2007 - 2:56 AM **Country:** Kenya

AD syringes are not widely used in Kenya. They are mainly used during national immunization days which are of course heavily sponsored by international donors. Therefore to address the issue, proper mechanism should be put in place to ensure regular supply of ADs should CBD of DMPA be introduced.

Name: [fredrick ochieno](#) - Thursday, May 24, 2007 - 3:09 AM **Country:** Kenya

Without proper sensitization and an all-inclusive approach, new technologies alone will not remove resistance. All stakeholders should be involved including the target communities. By the way resistance is not only expected from clinicians but should also be anticipated from unlikely sources like organizations championing for women rights that include access to quality RH (quality in terms of provider and the service).

Name: [Julie Wiltshire](#) - Thursday, May 24, 2007 - 3:15 AM **Country:** Uganda

The Uganda MOH is introducing the autodisable syringe and is currently conducting a public awareness campaign about it. I am not sure if this will change the current attitudes about CBD administration of injectable family planning methods or not, as I think some concerns about injection safety will still remain, despite the encouraging experience to date with the CBD pilot program in Uganda. The new proposed Depo Sub-Q has not yet reached public health facilities in Uganda, so the response is yet to be experienced, but I believe this will be a welcome step to expand family planning choices and options for women. If this means that potentially women could self administer the contraception as reported in Latin America, then some changes in RH policies and practices would be required at a Country level, and awareness raising at the community level, amongst other things. However I think we still need to understand more clearly the current practices used in managing side effects of the injectable contraceptives, which leads to discontinuation of the method, so that communities become better at utilizing the what is currently available. I also believe we will still find challenges in the districts, as CBD programs are not uniform across the Country; some are well supported and some are not, and this will need to be taken into consideration for any efforts at bringing new technologies to the community.

Name: [fredrick ochieno](#) - Thursday, May 24, 2007 - 3:20 AM **Country:** Kenya

In future, even with availability of new technologies, CBDs will need to undergo training and re-training that will enable them to not merely provide sub-Qs. The clients they are dealing with have a multiplicity of health problems and CBDs can play a crucial link in the referral system for such clients. Furthermore, the would-be self-injecting clients will still follow-up and counselling.

Name: [Jully Chilambwe](#) - Thursday, May 24, 2007 - 5:45 AM **Country:** Zambia

Auto Disable syringes are not very common in Zambia. If introduced on a larger scale, will definitely increase the medical injection safety by CBDS as well as the medical personnel. Objections mainly will come from the Clinicians whose clientele will be reduced by so many who will be accessing injectables through CBDS. It is possible that women in future may inject themselves with Depo sub Q like the diabetics but this requires them to undergo training. Such a training would be on a very large scale and requires so many trainers, counsellors, time etc. Where will all the resources come from?

Name: [Baba Issa](#) - Thursday, May 24, 2007 - 7:38 AM **Country:** Nigeria

Auto disposable are not common in Nigeria but available for nationwide immunization. It can be used for CBD if widely available. This would go a long way at overcoming some of the anticipated problems expressed by some commentators on this forum. I am fully in support of auto disposable syringes.

Name: [Jason Smith](#) - Thursday, May 24, 2007 - 11:23 AM **Country:** United States Of America

In discussions of this type I am always baffled by the notion of preserving clinician status. To my way of thinking, there is so much need for trained clinicians and they can do so much more than relatively simple tasks like injections and handing out pills, it would seem to me like they would be happy to increase their status by delegating (safely) things that others could do.

Re-orienting health systems so that they concentrate on providing only the services that no one else can do and putting anything that can be delegated into a community program or the private sector, would go a long way towards improving coverages and stretching scarce resources, especially trained medical human resources.

Name: [Kirsten Krueger](#) - Friday, May 25, 2007 - 9:44 AM **Country:** United States Of America

Posted on behalf of Ed Scholl - USA

What is the status of depo-subQ provera? Since it is approved by the FDA, are there plans for USAID to donate it to countries? Will it be socially marketed by anyone, or is it destined to be available only in the U.S. and other developed countries?

Name: [Kirsten Krueger](#) - Friday, May 25, 2007 - 9:46 AM **Country:** United States Of America

Poste don behalf of Dr Robertine Randriasamimanana, Project Director NGO PENSER Madagascar

Greetings dear All, I guess that new technologies will help the FP methods injectables for scaling up if the new DeposubQ is available as soon as possible and affordable for FP users. It means, again a good marketing social and key distribution. For my Country, there are always many illiteracy women; the use of Unijet by women themselves is very threatening. CBD with an acceptable background, trained and supervised with regular refresher training will more effective. [See additional post on linkages thread.] Best regards to everyone.

Name: [Kelsey Lynd](#) - Friday, May 25, 2007 - 11:38 AM **Country:** Madagascar

Hey again, Just to follow up on the discussion of autobloquant, SubQ and self injections. 1st. I am not sure how well self injections will go over in Madagascar. Yes, a very valid point being illiteracy and problems figuring out dates... but even more than that I really worry about the disposal of needles after... With our CBD agents we give them safety boxes and they are asked to return them when full to the clinics to burn them. I've seen too many "medical trash items" floating around in the hands of children here... and wouldn't want syringes to start floating around as well. 2nd. we do use the auto block needles here- during training we had our agents use non-block (normal) needles to get the feel of how to aspirate and such. Then we switched to the autoblock. One thing to remember is that during training and their initial following supervised injections is that the agents go through a lot of needles. I'd suggest having two autoblock syringes to every vial of DMPA during this period. 3. SubQ- yeah bring it on ASAP! We are all for it!

Thanks to everyone and your insight to this forum!

Name: [Sarah Harlan](#) - Friday, May 25, 2007 - 2:50 PM **Country:** United States Of America

FINAL REPORT: Virtual Forum on "Addressing Unmet Need for Family Planning in Rural Areas: Introducing Community-Based Distribution of Injectable Contraception"

In response to Ed Scholl's question about the availability of Depo Sub-Q: USAID is indeed planning to purchase Depo Sub-Q (in Uniject syringes) and will introduce it into FP programs; their goal is to have this started by 2008.

The following paragraph is excerpted from the May 2006 Report to Congress on Health-Related Research and Development Activities at USAID:

"In a move to expand the use of the injectable contraceptive Depo-Provera while also increasing injection safety and safe medical waste disposal, USAID has developed a public-private partnership with three entities: the Pfizer pharmaceutical company (Depo-Povera's manufacturer); the USAID-supported PATH project, which developed the Uniject injection device (a proprietary, prefilled device designed to prevent reuse); and Becton, Dickinson and Company, the world's largest syringe manufacturer and licensee of Uniject. With USAID's leadership, the parties have come to agreement, and Depo in Uniject should be ready for roll-out by 2008."

Day 5 – Discuss Thread

In your Country, could CBDs link with public sector facilities for supplies and referrals? How would clinic-based providers react to such an arrangement?

How can CBDs help women access long term and permanent methods that are unavailable locally?

Day 5 - Summary

Dear forum participants,

As we bring this week's discussion to a close, we want to thank all participants – both those who were in touch with us almost on a daily basis and those who quietly listened to what was being said. It is amazing that this one-week forum had as many as 315 registrants from 53 countries with around 100 postings (137 of you were participating via the website)! Special thanks to our guest experts who added details from their existing CBD of injectables programs and let us all know the reality of what works and what remains a challenge. Also, kudos to the forum organizers whose daily interactions and responsiveness on the 'behind the scenes' aspects of the forum were keys to the success of the entire online discussion.

Today's responses continued on several of the discussion threads. For the new technologies question, we heard more voices eager for the new subcutaneous formulation and auto-disable syringes to be available on a widespread basis. A couple of you thought that CBD provision would be more acceptable than self-injection due to concerns about literacy and waste management. We also saw new postings on the overcoming obstacles and the safe/effective threads which respectively reiterated the importance of funding and continuous training and the increase in acceptability of CBD of injectables if using the pre-filled, auto-disable, subcutaneous preparations.

For the linking to clinics discussion, nearly all of you believe that CBD of injectables programs should be linked to public sector health facilities (and already are in several countries) as a key to the sustainability and quality of the program. Linkages between CBDs and clinic staff should be started early and can include joint training, joint monthly meetings and reports, supervision, resupply, and even assistance from CBDs with other health initiatives such as immunizations or food distribution. Importantly, as Kelsey Lynd from Madagascar points out, these linkages "...allow [clinic providers] to see first hand if CBD agents can indeed successfully provide DMPA." She also notes that linking CBDs to NGO partners is successful in the Madagascar program because the, "NGOs provide further supervision by making visits to the CBD agent communities, assuring proper

reporting and resupplying all the agents management tools (registers, stock cards etc...). Our NGO's contributions to this project have been extremely valuable." A couple participants note that facility providers do, in fact, see CBDs as complementary to the clinic work and recognize CBDs for their important role in referrals, outreach, demand creation, and accessing hard-to-reach clients.

Referrals for long term and permanent methods (LAPMs) can be made by CBDs who are trained and supported in these types of methods. Referral networks must be well-established and included in CBD training. Dr. Peter Njorge says that in Kenya in spite of a decline in pills distributed and new and repeat clients seen in 2000-2004, "...the number of effective referrals for long term and permanent FP methods remained high, which could be explained by the expanded mandates of CBDs."

Even with strong linkages between CBDs and clinic-based providers, the challenges of stock-outs and staff turn-over may hamper success. Several of you commented on the need for CBD and clinic staff to be involved in joint planning,

forecasting, and requisition of commodities. In the Madagascar program, CBDs are connected to both the public and private sector for resupply. In the event of stock-outs at the clinic, there is another option for CBDs to get supplies which allows continuous service for clients.

Several of you who posted comments in the last day or two apologized for being late to log in, explaining that you had come from the field. No apologies needed—we should be thanking you for the expertise and realism you bring to the forum! The fact that a virtual conference such as this allows for your participation and those of hundreds of others, from the field and from headquarters, has made this forum a success. We have all learned much from one another in the last five days.

Please know that while the moderated discussion ends today, the website remains open. That means you can refer colleagues to the site to read all the postings and library documents, follow-up directly with other participants, and continue to add your thoughts and ideas. Also, you may be interested in continuing a discussion on injectable contraception, in particular, on The INFO Project Blog. Finally, please remember to complete the forum evaluation.

It has been a pleasure and honor to serve as moderators for the forum. We wish you the best of luck in your work and thank you all, once again, for participating in this forum.

- John and Kirsten

Day 5 – Postings

Name: [Hilda Sekabira](#) - Friday, May 25, 2007 - 4:08 AM **Country:** Uganda

Yes I think CBDS can link with public sector facilities for supplies and referrals. I think that is one way of ensuring supplies are available. Uganda's Ministry of Health, during the National Health Assembly 2006 said that it was rolling-out Village Health Teams. These could be used to link the CBDs to public sector facilities especially if the teams members have also been trained as CBDs.

Apart from increasing the clinic based providers' (CBPs) workload especially in facilities that are facing Human Resource challenges, I think the former would welcome the idea. However the CBPs have to be sensitised about linkages in case they think that the CBDs are taking away their work.

Helping women access long term and permanent methods that are unavailable locally might be a challenge. The way I see it, the CBDs can only refer the women to a health facility which brings us back to accessibility issues. How is the nearest health unit, e.t.c.

Name: [Sammy Ole Oinyiaku](#) - Friday, May 25, 2007 - 4:45 AM **Country:** Kenya

My sincere apologies for not being able to actively participate in the forum. I have been in the remote/rural areas working with the Maasai women and especially the youth of Kenya. Most CBDs in Kenya are strongly linked with public sector facilities either in the form of government facilities, or mission/NGO health units. Most of them are selected, trained and deployed to respective areas by the public officials. They therefore provide supplies and referrals to, in most cases, rural women who are otherwise unable to access them in the clinics. Clinic based providers on the other hand have been supportive owing to the realization that they are working in resource poor settings - read personnel, transportation and facilities. They therefore view the CBDs as playing a complementary role. With adequate training and support, CBDs can help women access long term and permanent methods. Caution must be applied here in the view that most of the permanent methods involve either surgical operations or highly demanding medical attention. Most CBDs can only provide prescriptive methods; a challenge that can be overcome. One way to overcome this could be the use of retired medical professionals as CBDs in the communities that they live or volunteer in.

Name: [Martha Bekiita](#) - Friday, May 25, 2007 - 5:19 AM **Country:** Uganda

Martha - Uganda

In response to Today's questions I believe, linking CBD to public sector health facilities is the answer to CBD sustainability after phasing out of the funding program like Save the Children. Linking should start right from the beginning of the program. Starting with the Ministry of Health and the District Health

offices making them appreciate the initiative, involving the lower health facility service providers in community mobilization, sensitization and selection of CBDAs, this has worked very well with Save the Children community programs. Training was done jointly with program staff and MOH district trainers who happen to be the supervisors of the health facility service providers at the lower level. CBD monthly meetings take place at the health facilities where the providers are represented. CBDAs also being able to help health workers when they are carrying out community health activities like immunization outreach, food distribution and community mobilization. So clinic-based service providers would see CBDAs as helpers and resourceful. Save the Children also helps the districts to lobby for contraceptive supplies from the National Medical stores, Field Health Extension workers carry out quarterly stock taking of supplies at hand, this is done at the facility and community levels in attempt to reduce stock outs at both levels.

Save and FHI in collaboration with DELIVER program trained all in-charges of health facilities in Logistic Management system to equip them with skills to plan, forecast and timely requisition of contraceptives. All these measure are taken to ensure that CBDAs have constant adequate supplies from the health facilities. Long-term and permanent methods CBDAs have created high demand for these methods, on the other hand oral pill use is declining. Majority women now prefer Depo provera, long- term and permanent methods, this has demoralized CBDAs who do not give depo provera, however, CBD are encouraged to make effective referrals and would be recognized for the efforts. Arrangements to facilitate outreach services from Mulago national hospital, it is an expensive and not sustainable venture but works, we did it in Nakasongola and was successful in a way that, the backlog of clients who needed the services was cleared living a few people who could be managed by te health center level four. CBDAs register clients for the services they want the medical team comes to work on them, as the team provides services at the same time they teach clinic-based service providers to insert and remove Norplants. However, the challenge of Government staff turn over affects services a lot we often facilitate capacity building for service providers in RH/FP services, like IUD & Norplant insertion, TL and Vasectomy then shortly after the training the trained staff get transferred.

Name: [Olusesan Makinde](#) - Friday, May 25, 2007 - 9:23 AM **Country:** Nigeria

I agree with Martha and the other contributors. For sustainability of the programme and better management of problems and situations that may arise from the application of the contraceptives as well as provision of longer term contraceptives, the CBD's should be actively linked to a health facility. The PHC center nearest to them where this mode of health delivery is the practice is a very good suggestion.

Name: [Kirsten Krueger](#) - Friday, May 25, 2007 - 9:42 AM **Country:** United States Of America

Posted on behalf of Dr. Peter Njoroge, Kenya

I welcome the opportunity to participate in this very important forum albeit on the last day. Below are my reactions to day 5 discussion questions.

Q 1 Kenya has extensive experience in linkages between public health facilities and CBDs for supplies and referrals through the successful GTZ-supported Ministry of Health CBD program that (among other CBD programs) made significant contribution to the impressive improvements in CPR and TFR experienced in the 1980s to mid-1990s before the stalling evidenced in the 2003 KDHS. CBDs were linked to the local rural health facilities for supplies, support supervision, reporting and referrals which worked quite well. In Kenya, health workers in the public health facilities recognize outreach activities, involving engagement with Community Own Resource Persons (of which CBDs are central), is an essential part of their work

Q 2 CBDs in Kenya play a much bigger role than just providing pills and condoms. They educate, advice, counsel and refer FP clients. This fact is reflected in their training curriculum. The further review of the 2003 KDHS observed that in spite of the sharp decline in the number of pill cycles distributed by CBDs in the major CBD programs between the years 2000 and 2004, with a corresponding drop in the numbers of new and repeat clients, the number of effective referrals for long term and permanent FP methods remained high, which could be explained by the expanded mandates of CBDs. Many thanks

Name: [Kirsten Krueger](#) - Friday, May 25, 2007 - 9:49 AM **Country:** United States Of America

Posted on behalf of Dr Robertine Randriasamimanana, Project Director NGO PENSER Madagascar

For the link with public sector, in Madagascar it is smoothly improved (lessons learned on Champion Communities) and with marketing social, PSI. It looks the best way for improving access widely.

Name: [Kirsten Krueger](#) - Friday, May 25, 2007 - 9:51 AM **Country:** United States Of America

Posted on behalf of Jane Otai - Kenya:

CBD can easily be linked to the existing health facilities. Only yesterday, I held a community meeting with the slums community in Nairobi in which we were advocating for uptake of FP in the community. The facilities for this meeting with the government representatives i.e. the District medical officer of health, in-charge of the local health facility and the district public health nurse. In this meeting the community expressed a desire to have contraceptives distributed by the CBDs. In this case they referred to pills since it's the method that is commonly used in this community. The DMOH assured the community that the health facility would be able to supply the pills through the CBDs. However, the challenge is that even as this was being discussed, the health facility had run out of injectables and pills for the last two weeks. Thus while thinking of having the CBDs offer injectables, the supplies side should be well established or else this will be a disaster. Jane

Name: [Kirsten Krueger](#) - Friday, May 25, 2007 - 9:54 AM **Country:** United States Of America

Posted on behalf of Dr Jude Amechi Ilozumba Clinical Services / PMTCT Officer Global HIV/AIDS Initiative - Nigeria

Thank you very much for all the enlightening and thought provoking discussions. I have been following the discussions from day one though field work could not allow me full participation. There is no access to internet in the field.

Coming to the day's question, CBD could link with public sector facilities in my Country for supplies and referrals based on the following;

The public sector facilities as the name implies is for the general public and services are relatively cheaper. Other facilities mostly the faith based where FP services are not being provided can be linked to the public facilities for service provision and uptake. All that is needed in the public sector is the political will and the commitment of the staff of the public sector facilities with the provision of the enabling environment for the services to be fully operational. There is also the area of public enlightenment and education for the need for family planning and child spacing. The clinic based provider reaction will be that of involvement in the planning and referral linkage in the chain of service provision. But a note of caution is that in my own part of the Country, people patronize the private clinic – based service providers more than the public sector because of the feeling of the personalized services they receive in the private clinic – based facilities. Another sector that receives great patronage is the faith based health institutions. Most of these faith based institutions (Catholic owned institutions) do not offer family planning services.

I hope that with the contributions of the participants, a new course will be charted in the area of FP using the injectable contraception mostly in the rural communities.

Name: [Kelsey Lynd](#) - Friday, May 25, 2007 - 11:22 AM **Country:** Madagascar

Like a lot of you, I've been without email access this week, as we've been preparing for our M&E portion of this CBD DMPA project... an exciting phase for sure. So just to respond to what I've been able to read so far... Yes, I agree it is very important to link the CBD agents to public health facilities. That is what we do here and for the most part it works great! Every month our CBDs turn in their reports to the clinics and they also are resupplied there as well. This also creates a wonderful collaboration between the clinics and the CBD agents. A must have for starting up CBD of Depo as it assures that everyone in the health sector; from the clinic providers up to the MoH is onboard and allows them to see first hand if CBD agents can indeed successfully provide DMPA. Now having said all that, in addition with linking our CBD agents to the clinics we also link them to the NGOs. These NGOs provide further supervision by making visits to the CBD agent communities, assuring proper reporting and resupplying all the agents management tools (registers, stock cards etc.) Our NGOs contributions to this project has been extremely valuable. Lastly, in discussing supply chain of DMPA. Here in Madagascar, the public sector

contraceptives are about half the price as the private sector's. However, I would argue that for both the clinics and the CBD agents, having access to both is very important. 95% of the time our clinics and CBDs are able to resupply successfully through the public market... however; there are a few (now rare) times when there might be a stock out (this could be due to a late order or bad road conditions etc...) and during this time our providers pull from the private sector so that they are still able to meet their clients' needs. In my opinion it is important to allow more than one option to avoid problems in stock and such. In closing, linking the CBDs to public clinics but also having the support of the NGOs seems to be the way to go here in Madagascar.

Name: [ADEYEMI ADEKUNLE](#) - Friday, May 25, 2007 - 11:59 AM **Country:** Nigeria

Certainly, CBD Agents can link with public sector clinics for supplies and referrals. I also agree that a good relationship between CBD Agents and clinic staff will ensure smooth referrals but training programmes for CBD Agents hardly include modules on referral networks/systems. And how many FP programmes have clearly defined referral networks? Referral goes beyond just sending a client to the nearest clinic for a higher level of care/service or for supplies. It should be a two-way system to allow a cross-fertilization of ideas between the CBD Agent and the service provider in the clinic, i.e. the CBD Agent should be able to benefit from the experience of how a more skilled provider manages a particular client referred. We should ensure that a good referral system is a strong component of any CBD Injectable program.

Name: [Chukwuyem Okoh](#) - Friday, May 25, 2007 - 1:00 PM **Country:** Nigeria

Definitely CBDs could link with public sector facilities for supplies, etc provided there is proper planning and involvement of all relevant stakeholders at the outset. Infact, one ongoing CBD program (excluding injectables) under the IRIN Project of the USAID is proceeding well in parts of South East Nigeria (Abia); involving both private and public facilities. As long as roles and concepts are clarified from the beginning such initiatives would usually proceed satisfactorily

Name: [olukunle omotoso](#) - Friday, May 25, 2007 - 4:16 PM **Country:** Nigeria

CBD could be definitely linked. But we must also make provisions for the possible breakages in the link which could come as a result of communication gap, and responsibilities of each party concerned.

Name: [omowumi ajaqbe](#) - Saturday, May 26, 2007 - 5:24 PM **Country:** Nigeria

Dear John and Kirsten,

I was away to a rural community for a training assignment a day to the take off of the seminar. I thought I would be back to the city to access my mails and make my contributions to the discussion before weekend. Unfortunately, I was not able to. Though my contributions may not reach all contributors, but I hope the organizers would find one or two suggestions useful in planning and implementing this laudable idea of community-based distribution of injectables in countries like Nigeria where they yet exist. Permit me to give a little background of myself. I served with the Oyo State Hospitals Management Board and Ministry of Health in Nigeria for 21 years before retiring voluntarily. The last 8 years of my service with my State was spent as the Deputy State Family Planning/Zonal CBD Coordinator. I was involved in training, supervising, and coordinating clinic-based and community based distribution of contraceptives/ treatment of minor ailments sacroes all local governments areas (especially rural communities).

Up till today, I am still much involved with working in rural communities. In many rural communities in Nigeria, women don't have adequate access to family planning. Though, providing injectable contraception by community-based agents would improve access to FP, a lot of measures need to be put in place in Nigeria to make it effective and safe. At the initial take off of CBD contraception in Nigeria, CBDs were offering simple FP methods with FP pills. But at the time of training, the CBDs simple checklist to screen potential clients for pills for contraindications, were taught to the CBDs and made available in their CBD kits. For years, the CBDs were dispensing simple FP methods and pills. However, periodic evaluation revealed that appropriate screening of the clients were not done by the CBDs all the time and clients were using the pills not as prescribed. To forest all damage to the health of the clients,

the pills were withdrawn from the CBD kits, and the CBDs were motivating like FP, dispensing simple FP methods like Condoms, Vaginal Foaming Tablets (it was available then) and referring clients to the nearest Primary Health Centre (PHC) for other prescriptive methods.

However, if one considers the high material mortality rate in Nigeria and the great risks of pregnancy and childbirth run by rural women with inadequate access to FP Services, and the fact that most of these women are poor, one needs to reintroduce more reliable methods like injectables alongside with other methods to ensure method mix at the community level with special focus on rural communities. This time around the introduction of CBD of I njectables and reintroduction of pills with other simple FP methods must be with a different approach, to ensure safety.

The following are my suggestions:

1. That the criteria for selection of volunteers for this program must be revised. Instead of the previous, volunteers may be literate or non-literates, one of the criteria must be that volunteers (future CBD agents) must be literate with at least primary six school leaving certificate or adult literacy certificate. (This is in addition to other set criteria). These CBDs + call primary CBDs. They are to be properly trained as motivators for FP and can dispense the non-prescriptive methods.

But, 2. Another set of CBDs which I, Christen Secondary CBDs (20 CBDs or CBD heads should be trained along with them. These secondary (20)CBDs or Heads must have some in Nigeria context, JSS3 education at least. These ones will have additional training on making injections safe, infection prevention and control. They will also be offered some form of supervisory skills training. They will offer the CBD Depo-subQ injectables (and not the conventional Depo-Provera) with auto-disable syringe. These CBD heads or 20 CBDs will be evenly selected among the rural communities to ensure they are all well served. The additional training given to them is to ensure safety and the Depo-subQ suggested s to minimize side-effects and complications.

3. Selected Health workers interested in FP rural Primary Health Centres, should be trained/retrained in Family Planning with emphasis on the Depo-subQ which is an innovative technology in Nigeria. They will also provide all forms of FP except permanent methods and implant which they are not trained on. In addition, these PHCs will serve as referral points for the CBD heads when side-effects and complications from Depo cannot be handled by her. The CBD heads will.

4. In order to ensure sustainability of the program and for continual supervision of the CBDs and re-supply of communities beyond funding; capable. Non-governmental/community-based organizations (NGOs/CBOs) should be identified at the commencement of the program. They should be update in FP information and services; offered trained in Infection Prevention and Control as well as Supervisory skills. These NGO/CBO partners should work in collaboration with the local government partners to ensure smooth running of the program beyond project period. Contraceptives and consumables should be kept with them. These NGO/CBO partners collaboration with local government (LGA) partners should track statistics and work together for onward transmission to appropriate quarters.

5. Currently, Nigeria has a standard of practice (SOP) for Fp. Before introducing the Depo-subQ, a group of consultants should be identified to review and update the SOP with emphasis on the provision of injectables module. The manual should be pre-tested across the nation and updated before final publication. The module on the injectable should be mass-produced in made available to all the trained BCD heads, PHC, Health Centres and the NGO/CBO partners participating to ensure adherence and compliance by all providers and supervisors of the program. The checklist and other screening tools should be revised and be made to be part of the updated SOP for FP.

6. To ensure full accessibility of the Depo-subQ injectable, the finances must heavily subsidize the product. One of the reasons why female condom is accepted in Nigeria is the fact that cost is heavily subsidized.

7. In order to overcome medical, political obstacles, resistance, myths, misconceptions about CBD of injectables and gain support of all stakeholders, the following groups of peoples should be stories of other programs be told: (a) Government parastatals especially Federal Ministry of Health. (b) Professional Associations of Nurses and Midwives, Doctors, Pharmacists (c) Religions leaders across Religions and Denominations (d) Community leaders (e) Market Women Association leaders (f) Women of Reproductive Ages and their partners In rounding off, permit me to reemphasize that if all necessary stakeholders are properly sensitized, adequate training is given to all providers at all the levels

proposed, the SOP for FP is updated, CBDs are properly selected using set criteria and injection safety is guaranteed through the training and compliance to infection prevention and control and Depo-subQ injectable is administered with the use of non-reusable auto-disable syringes, the limit to the success of the program cannot be limited.

However, I strongly suggest that in Nigeria, rural women should not be saddled with injecting themselves. This act may lead them not to go for follow-up at the PHCs; they may be Christened Doctors in their local communities; this may eventually lead to quackery. It can happen in Nigeria and it must be prevented right from the onset. Thanks you for allowing me to participate.

Name: [Kirsten Krueger](#) - Tuesday, May 29, 2007 - 3:09 PM **Country:** United States Of America

Posted on behalf of Penina Ita - ACT, NAMIBIA

I feel that my previous questions are not answered, but today I want to contribute to the importance of involving the government in the CBD's project. The government, especially the ministry of health involvement in the program is crucial because the ministry of health reach outs to rural area throughout the clinics or districts health facilities set ups. They will also advise, and make better recommendation. The private sector is also needed to provide resources e.g. training, community awareness, producing educational materials just to mention few as well as providing resources. In many occasions, if services or products are distributed for free, many times dependency precedence conditions are created. Is sustainability ensured? If so, what are the mechanisms in place to ensure community ownership?

Thank you Kirsten and John for keeping the dialogue active.

APPENDIX 2:

“CBD of Injectables” resources, included in the GEN Library

ADVOCACY

[Improving Access to Family Planning: Community-based Distribution of DMPA](#). Research Triangle Park, NC: Family Health International (FHI), 2007.

This advocacy kit, developed by Family Health International, targets decision-makers and program managers. It includes seven research and program briefs, plus resources and steps for implementation.

OVERVIEW

Phillips JF, Greene WL, Jackson EF. [Lessons from Community-based Distribution of Family Planning in Africa](#). New York, NY: Population Council, 1999.

Shears, KH. [CBD of Injectables](#). Network, Vol. 22, No. 3. Research Triangle Park, NC: Family Health International (FHI), 2003.

Stang A, Schwingl P, Rivera R. [New contraceptive eligibility checklists for provision of combined oral contraceptives and depot-medroxyprogesterone acetate in community-based programmes](#). *Bull WHO* 2000;78(8):1015-23.

Wright, KL and Shears KH. [Single-Use Injectable Devices Address Barriers, Concerns](#). Network, Vol. 22, No. 3. Research Triangle Park, NC: Family Health International (FHI), 2003.

COMMUNITY-BASED DISTRIBUTION (CBD)

[Community-Based Distribution](#). Network, Vol. 19, No. 3. Research Triangle Park, NC: Family Health International, 1999.

This issue of *Network* is dedicated to the topic of community-based distribution of contraception. Articles examine research on programmatic issues, and highlight services in Peru, Bangladesh and Zimbabwe.

Prata N, Vahidnia F, Potts M, et al. Revisiting community-based distribution programs: are they still needed? *Contraception* 2005;72(6):402-7. [ABSTRACT](#)

INJECTABLES

[Expanding Contraceptive Choice: Integrating Injectables into NGO Family Planning Services](#). Washington, DC: Centre for Development and Population Activities (CEDPA), Enabling Change for Women's Reproductive Health (ENABLE), U.S. Agency for International Development (USAID), 2003.

[Injectables Toolkit](#). INFO Project.

This online resource provides up-to-date information, guidance and tools for researchers, program managers, providers and other health professionals.

Lande R, Richey C. [Expanding Services for Injectables](#). *Population Reports*, Series K, No. 6. Baltimore, MD: INFO Project, Johns Hopkins Bloomberg School of Public Health, 2006.

FINAL REPORT: Virtual Forum on “Addressing Unmet Need for Family Planning in Rural Areas: Introducing Community-Based Distribution of Injectable Contraception”

Within Series K, No. 6: [Injectables Tomorrow: Subcutaneous DMPA and Home Injection](#).

Lande R. [New Era for Injectables](#). *Population Reports*, Series K, No. 5. Baltimore, MD: Johns Hopkins School of Public Health, Population Information Program, 1995.

COUNTRY REPORTS

Garza-Flores J, Del Olmo AM, Fuziwara JL, et al. Introduction of Cyclofem once-a-month injectable contraceptive in Mexico. *Contraception* 1998;58:7-12. [ABSTRACT](#)

[Innovations in Family Planning: The Accelerating Contraceptive Use Project in Afghanistan](#). Cambridge, MA: Management Sciences for Health (MSH), 2007.

McCarraher D, Bailey P. Bolivia: Depo-Provera provision by community based distribution workers and other CIES staff in El Alto. Unpublished paper. Research Triangle Park, NC: Family Health International (FHI), 2000. (NOT AVAILABLE ONLINE)

Ria C, Thapa S, Bhattarai L, et al. Conditions in rural Nepal for which DMPA initiation is not recommended: implications for community based service delivery. *Contraception* 1999;60:31-37. [ABSTRACT](#)

Stanback J, Mbonye A, LeMelle J, et al. [Final Report: Safety and Feasibility of Community-Based Distribution of Depo Provera in Nakasongola, Uganda](#). Research Triangle Park, NC: Family Health International (FHI), 2005.

MANAGEMENT

[Checklist for Screening Clients Who Want to Initiate DMPA \(or NET-EN\)](#). Research Triangle Park, NC: Family Health International, 2006.

This checklist is intended for use by both clinical and nonclinical health care providers, including community-based distributors, to help screen clients who have made an informed decision to use DMPA. The checklist is based on the World Health Organization's Medical Eligibility Criteria for Contraceptive Use (WHO, 2004). FHI also developed a [Reference Guide](#) for the provider checklists.

[Checklist: How to Be Reasonably Sure a Client is Not Pregnant](#). Research Triangle Park, NC: Family Health International, 2006.

This checklist is intended for use by family planning providers to help non-menstruating clients safely initiate their method of choice.

[Introducing Auto-Disable Syringes and Sharps Disposal Containers with DMPA](#). Program for Appropriate Technology in Health (PATH), U.S. Agency for International Development (USAID), 2001.

[Management of Waste from Injection Activities at District Level: Guidelines for District Health Managers](#). Geneva, Switzerland: World Health Organization (WHO), 2006.

Neresian P, Cesarz V, Cochran A, et al. [Safe Injection and Waste Management: A Reference for Logistics Advisors](#). Arlington, VA: John Snow, Inc./DELIVER for the U.S. Agency for International Development (USAID), 2004.

Price N. [Service Sustainability Strategies in Sexual and Reproductive Health Programming: Community-based distribution](#). London, England: DFID Resource Centre for Sexual and Reproductive Health, 2002.

FINAL REPORT: Virtual Forum on "Addressing Unmet Need for Family Planning in Rural Areas: Introducing Community-Based Distribution of Injectable Contraception"

[Procuring Single-use Injection Equipment and Safety Boxes \(A Practical Guide for Pharmacists, Physicians, Procurement Staff and Programme Managers\)](#). Geneva, Switzerland: World Health Organization (WHO), 2003.

Solter C. [Comprehensive Reproductive Health and Family Planning Training Curriculum. Module 6: DMPA Injectable Contraceptive](#). Watertown, MA: Pathfinder International, 1997 (revised 1999).

[The Manager: Leading Changes in Practices to Improve Health](#). Volume 13, Number 3. Management Sciences for Health (MSH), 2004.

Training Manual for DMPA Provision by Community-Based Reproductive Health Workers in Africa. Family Health International, 2004. (NOT AVAILABLE ONLINE)